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An Exploration of Medical Social Workers' Participation in a Grief Education Seminar

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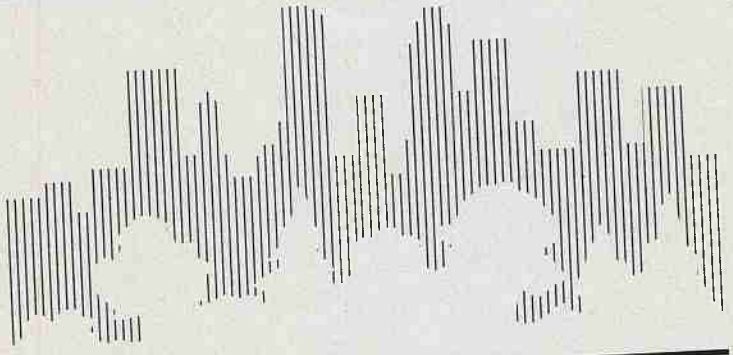

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MASTERS IN SOCIAL WORK THESIS

Colleen Marie Hoffman

ploration of Medical Social Workers' Participation in a Grief Education Seminar

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AN EXPLORATION OF MEDICAL SOCIAL WORKERS' PARTICIPATION IN A GRIEF EDUCATION SEMINAR

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DEDICATION

This thesis is dedicated to my sister, Kathleen Petersen and children Kelly, Erick, and Emily, who lost their husband and daddy, Tom, to a sudden heart attack, July 1995. You have my enduring love and admiration for your courage and strength in the grief journey and the distance traveled.

For my parents, Marcel and Deanna Hoffman, the depth of your patience, love support and belief in me have carried me through many hours of research, writing and revisions. Thank you. To the rest of my family in Montana, Mike, Karen, Ben, Marce and Beth, thanks for all the long distance support and encourargement. To all of you, I dedicate this poem:

Our family is a circle of strength and love,
with every birth and every union
the circle grows.
Every joy shared adds more love.
Every crisis faced together
makes the circle stronger.

Anonymous

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ABSTRACT

AN EXPLORATION OF MEDICAL SOCIAL WORKERS' PARTICIPATION IN A GRIEF EDUCATION SEMINAR

EXPLORATORY DESCRIPTIVE STUDY OF A PROGRAM DESIGN, IMPLEMENTATION AND EVALUATION

COLLEEN MARIE HOFFMAN

MAY 9, 1997

The purpose of this study was to design, implement and evaluate a grief and death educational seminar for medical social workers at Hennepin County Medical Center in Minneapolis, Minnesota. This study described a seminar designed by the researcher: "The Grief Journey: Our Patients, Ourselves" and presented findings of the survey questionnaire and program evaluation. The study used primarily qualitative data to evaluate the preparedness of medical social workers in assessing grief after participating in a grief education seminar. The study population (n=23) were men and women participants of the grief education seminar presented January, 1997. The survey questionnaire and evaluations served as the pretest and posttest and focused on measuring levels of social workers' perceptions of their preparation to work with patients and families related to grief. The findings indicate personal death awareness and knowledge of grief increased comfort and assessment skills when working with patients and families experiencing grief.

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CHAPTER ONE

INTRODUCTION

AN EXPLORATION OF MEDICAL SOCIAL WORKERS' PARTICIPATION IN A GRIEF EDUCATION SEMINAR

"For life and death are one, even as the river and the sea are one."

Kahil Gibran

Overview

Everywhere in history, humankind has been concerned with mortality. Philosophy, religion, and science have all been involved in attempts to understand and control death. In spite of these efforts, death continues to be inevitable and this knowledge determines how we look at life (Rando, 1984). Historically, our nation rejoices at the arrival of new life and celebrate when individuals recover from illness, but do little to prepare people for death (Kingma, 1994). We live in a death denying society (Feldman, 1987; Kubler-Ross, 1969; Steinmetz & Gabel, 1992). Death in our society has often been identified as a taboo subject (Lister & Gochros, 1969). Aristotle observed that "death is the most terrible of all things" (Mckeon, 1941, p.975). "To most people, death remains a hidden secret, as eroticized as it is feared"(Nuland, 1994, p.xv). This research studied medical social workers' participation in a grief education seminar. The seminar: "The grief journey: our patients, ourselves," was designed to explore social workers personal grief awareness and increase their bereavement assessment skills.

Today, with the possibility that life can be prolonged indefinitely, the statement, "death denial" takes on new meaning because what many people fear now is a "medical death" or a "bad death" by technologically prolonging life at the expense of any quality of life (Hawkins, 1991). Our current health care system is often effective in curing people

but lacks in efforts to help people negotiate successfully in the passage between life and death. In America, almost 80% of people die in hospitals or nursing homes (Doka, 1993). Today, modern dying takes place in hospitals where it can be hidden and packaged for modern burial (Nuland, 1994). Many patients may be subjected to overzealous maintenance or overly aggressive treatment as medical staff seek to ward off death (Doka, 1993). Health care education follows this cultural trend. A national survey notes that professional schools of nursing, medicine, pharmacy, dentistry, and social work do not offer courses on death and dying (Kingma, 1994). Typical graduates have had only a "lecture or two" about death and dying integrated into other courses. According to a survey by the American Medical Association, only 8% of medical schools in the United States have a required course of study in issues related to dying and death (MacDonald, 1995). For many physicians, death represents a failure with which they are unable to cope, therefore, interactions with patients and their families is often avoided (Holman & Rappaport, 1991).

There is an identified need for social workers in health care to cultivate their skills and ability to relate to dying patients and grieving families. The Council on Social Work Education does not yet provide curriculum content related to dying and death (CSWE, 1994). In this study, the significance of guidance and preparation will be discussed as it relates to providing care to the bereaved, thus minimizing the need for trial and error. This study will contribute to filling the gap of experiential grief and death education specific to medical social workers. The primary emphasis of this grief research and the determinants of grief relates to the adult experience and provides an overview of the multiple factors that may complicate grief.

The subject of grief and death can be uncomfortable for anyone; medical social workers are not exempt from these feelings and experiences. Medical social workers often practice in environments where death occurs frequently. Working with dying patients and their families may be social workers most emotionally difficult challenge (Moore, 1984).

Hennepin County Medical Center (HCMC), a level one trauma center is a public teaching hospital comprising 437 hospital beds including more than one hundred intensive care beds, in downtown Minneapolis, Minnesota. HCMC is identified as an environment where death occurs frequently. In 1996, there were 347 inpatient deaths (includes both Adult and Pediatric population) out of 20,239 admissions to HCMC. In addition, there were 75 adult or pediatric deaths reported in the Emergency Department out of 73,611 patients served the same year. Consequently, medical social workers at HCMC are often called upon as members of the multidisciplinary team to address patients and families in the midst of a death-related crisis.

Much of social work education is for the purpose of preparation for life. Grief and death education is crucial to assisting social workers to cope with loss issues. The inevitability of death as a natural phenomenon suggests that we as professional social workers have a responsibility to deal with subject of grief and loss. Flexibility is an essential hallmark of helping professionals throughout the grieving process (Doka, 1993).

Research purpose and significance

The first and ultimate purpose of this research is to explore the aspects of loss upon social workers' lives and health as well as the lives of patients, families and colleagues. The second purpose of this research was to implement and evaluate a grief educational seminar designed by the researcher: "The Grief Journey: Our Patients, Ourselves" offered to medical social workers employed at HCMC. The third purpose of this seminar was to educate medical social workers in the multiple facets of grief with an emphasis on personal death awareness and how medical social workers in a hospital can better assist individuals who are grieving.

The goal of the seminar was to increase social workers' bereavement assessment skills and to enhance preparedness to work with patients and families in their grief experiences. The training also provides each participant the opportunity to examine their own feelings related to grief, death, and dying through experiential learning. The

objectives of the seminar were: to increase the personal death awareness of social workers, to provide an enhanced understanding of the psycho-social (emotional) process of dying, to identify at least two theories and possible difficulties with the grieving process, to provide age and circumstantial specific resources in the metropolitan area, and finally to offer social work assessment and intervention strategies for families experiencing grief and loss.

The potential significance of this study is the ultimate increased skill and knowledge (preparation) of medical social workers providing counseling to those in grief and mourning. The continuum of this knowledge and life experience related to grief, dying and death should include knowledge about the dynamics and issues germane to all phases (International Work Group on Death, Dying and Bereavement, 1991; Rando, 1994).

Origin of researcher's interest

The researcher's cumulative personal and professional experiences in grief education and death awareness was the impetus for this research. Exploring the impact of grief and loss in the context of social worker's relationships, values and physical and mental well-being enhanced the researcher's understanding of how these factors parallel the experiences of patients and families. Facilitating self-help grief support groups, participating in a Pastoral Bereavement Counseling course, clinical counseling internship at the Burnsville Counseling and Grief Center, in addition to twelve years of medical social work experience were the researcher's foundation for learning about grief. The true grief experts, those who have shared their pain and reidentification stories gave distinction to this journey and value to the process.

Overview of research question

While the overall purposes of this research are to explore, implement and evaluate a grief education seminar, the central question is: Are medical social workers better prepared to assess grief issues after participating in a grief education seminar?

Overview of chapters

This chapter discussed the need for social workers in healthcare to cultivate their skills in preparation for working with dying patients and grieving families. An awareness of the need for experiential death education was introduced. Chapter two will review the literature on theoretical frameworks of grief, variations on grief, personal death awareness and medical social work interventions. Chapter three will discuss the methodology and contains the research study design which demonstrates steps in implementation. The presentation of findings are explained in Chapter four. Chapter five will discuss the study's findings, conclusions and implications for social work practice.

CHAPTER TWO: LITERATURE REVIEW

Overview

This integrative literature review focuses on the major contributors of grief work, theoretical frameworks of grief, the variations on grief, the importance for personal death awareness for medical social workers and social work interventions. Many grief researchers and theorists have proposed varied conceptualizations to explain normal and complicated grief. These grief models have ranged from psychoanalytic thinking to the attachment model as well as stage and task models. More recently, attention has been given to the use of the Diagnostic and Statistical Manual of Mental Disorders (4th ed.; DSM-IV) (American Psychiatric Association, 1994) designation of posttraumatic stress disorder (PATS) as an additional conceptualization to understand the grief process (McNeil, 1995). The review of the literature discusses the meanings of grief concepts and attempts to clarify the learning process and the need for inner awareness for medical social workers.

Major contributors of Grief Work

The following is a synopsis of theories of bereavement and primary contributors in an effort to explain the dynamics of bereavement. The first of these contributors is Sigmund Freud who published his classic paper "Mourning and Melancholia" in which he undertook to define the normal process of grief and provides the theoretical foundation for much of the scientific examination of bereavement (Rando,1983; McNeil, 1995). Freud identified the significant features of bereavement and wrote of the grief work that must be done for the survivor to recover from the pain of loss. He emphasized the need for the bereaved to decathect (withdraw psychic energy) from the deceased and reinvest it into a new relationship.(McNeil, 1995).

A major contributor of grief investigation is Lindemann (1944). Lindemann is known for his study following the tragedy of the Coconut Grove Fire in Boston in 1944 in

which he wrote about acute grief as a normal reaction to a distressing situation. Lindemann focused attention on physical symptoms and reinforced the concept of grief work. In his search to differentiate normal form morbid grief, Lindemann (1944), identified nine distortions of the grieving process: (1) overactivity without a sense of loss; (2) symptoms of hysteria or hypochondria's; (3) presence of psychosomatic conditions; (4) changes in relationships with relatives and friends; (5) extreme hostility directed toward specific people; (6) struggle against hostility; (7) loss of patterns of social interaction; (8) engagement in self-destructive (non-suicidal) activities; and (9) agitated depression. Another aspect of Lindemann's work was operationalization of three tasks necessary to complete grief work: (1) emancipation from bondage to the deceased, (2) readjustment to the environment in which the deceased is missing, and (3) the establishment of new relationships. Lindemann and Freud are the two most frequently quoted early theoreticians in the field of bereavement (McNeil, 1995; Rando, 1983, 1993; Worden, 1991).

Another leading authority of grief theory is John Bowlby who is recognized as the originator of the attachment model. His basic belief was that individuals are profoundly motivated and affected by attachment and seek to maintain that attachment. Bowlby (1980) found many more features representative of normal grieving than have other researchers. For example, anger and the intense effort to recover and reproach the lost one are normal components of the grief process. In his attempt to normalize the grief process, Bowlby (1980) suggested four phases of mourning:

1. numbing that usually lasts from a few hours to a week and may be interrupted by outbursts of extremely intense distress and/or anger
2. yearning and searching for the lost object, which can last for months and sometimes for years
3. disorganization and despair
4. reorganization (p.85).

Bowlby observed infants and children and their responses to the loss of the mother or a primary attachment figure. He provided evidence that this behavior is essentially the same as that seen in an older child or adult who has suffered the loss of a loved one (Rando, 1993).

Theoretical and Conceptual Frameworks of Grief

There are three dominant theories all having sequential buildup to recovery. The three major theorists give different names to the process; Kubler-Ross names them as stages, Worden labels them tasks and Rando identifies them as processes. Kubler-Ross is the preeminent authority on dying and grief and her theory provides the foundation for more recent theories. This study focused primarily on the theories of Kubler-Ross, Worden and Rando for their relevant conceptual frameworks that can be applied to medical social work.

Elizabeth Kubler-Ross (1969) Stages of Grief

1. Denial and Isolation
2. Anger
3. Bargaining
4. Depression
5. Acceptance

Kubler-Ross's conceptualization created a model for understanding both the cognitive and psychological movement along the death continuum. Her model can be while applied to people suffering losses other than death such as loss of a body part (i.e.: amputation, spinal cord injury or a degenerative condition that leads to progressive physical deterioration. Her theory has been applied to the grief experience of the survivor as well as the patient (McNeil,1995).

J. William Worden (1991) identifies the four tasks of mourning one must go through for healthy grieving.

Worden's "four tasks of mourning" are:

1. to accept the reality of the loss,
2. to experience and work through the pain of grief,
3. to adjust to an environment in which the deceased is missing, and
4. to withdraw emotional energy from the grieving process and reinvest it in another relationship. To be able to 'let go' and 'move on' with his or her life.

The first of Worden's tasks recognizes that the death must become real before you can work through the process of grief. The second addresses the need to do specific things to express those emotions generated by the death. The third stresses the importance of analyzing the different roles the deceased played in one's life and to make adjustments which will enable the person to build a new life. The last focuses on the possibility of personal growth (Worden, 1991). This model is congruent with the concept of grief work and empowers bereaved people by providing tasks to achieve and provides a sense of leverage.

Worden (1991) outlines the manifestations of normal grief with regard to feelings, cognition, and behaviors expressed during a time of grief and mourning. Any of the following feelings may be experienced while grieving: sadness, anger, guilt, self reproach, anxiety, loneliness, fatigue, helplessness, shock, yearning, relief, and numbness. Some cognition's people may experience during a time of grief are: disbelief, confusion, preoccupation, a sense of presence, and hallucinations. Behaviors people may experience while grieving a loss are: sleep disturbances, appetite disturbances, absent-mindedness, social withdrawal, dreams of the deceased, sighing, crying, restlessness or over activity, and treasuring objects or photos of the deceased.

"R" Processes of mourning

The third theory relevant to medical social work was developed by Therese Rando (1993) whose work with complicated mourning inspired her to write the six "R" processes of mourning necessary for healthy accommodation of loss.

Rando's "R" processes are outlined as follows:

1. Recognition of the loss: Acknowledge the death. Understand the death.

2. React to the separation: Experience the pain, feel, identify, accept, and give some form of expression to all the psychological reactions to the loss. Identify and mourn secondary losses.

3. Recollect and reexperience the deceased and the relationship: Review and remember realistically. Revive and reexperience the feelings.

4. Relinquish the old attachments to the deceased and the old assumptive world.

5. Readjust to move adaptively into the new world without forgetting the old: Revise the old assumptive world. Develop a new relationship with the deceased. Adopt new ways of being in the world. Form a new identity.

6. Reinvest, (Rando, 1984, p. 255-256).

In all forms of complicated mourning, there are attempts to do two things: First, to deny, repress, or avoid aspects of the loss, its pain, and the full realization of its implications; and secondly, to hold onto, and avoid relinquishing the lost person. These attempts are what cause the complications as outlined in the "R" processes of mourning.

Rando (1984) cites Lindemann's early work on the phenomenon called "grief work". "These words describe one piece in the process of grief being that if an individual does not successfully complete their grieving for themselves, they will need to revisit grief when another death or loss occurs in their life" (Rando, 1984, p. 21).

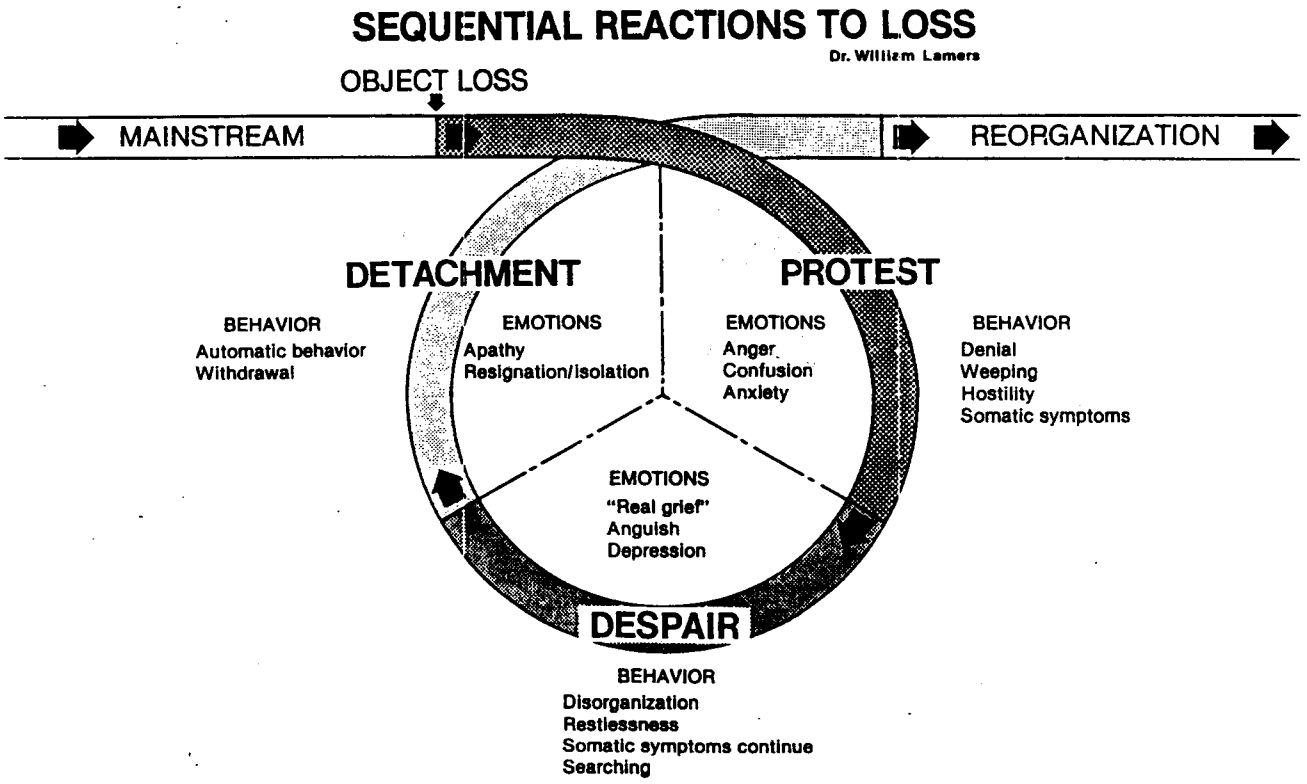
The subject of death and grief came to the American forefront almost thirty years ago when Elisabeth Kubler-Ross published her pioneering work, On Death and Dying (Oakland, 1982, Corr, 1992, Worden, 1991, Rando, 1984). Kubler-Ross developed a conceptual framework of five stages of grief which are denial, anger, bargaining, depression, and acceptance. Initially perceived to occur in this given order, it

has become more accepted that individuals go through these stages not in a linear fashion per se but circular and at their own pace and time frame. The flexibility of Kubler-Ross' theory is that it can be applied to all cultures and ages and remains an accepted theory to date.

One of the criticisms of this analysis has been the expectation some people have that each of these stages will proceed in that precise order, and then pass. This perceived expectation has proven frustrating to those who want the grief process to be clear and orderly (Corr, Nabe & Corr, 1997; Kubler-Ross, 1969; Obershaw, 1992; Rando, 1984; Worden, 1991). Grief is often seen as linear but it is actually circular (Corr et.al. 1997). Grief is a process, and the following illustration (Figure 1) depicts The Sequential Reactions to Loss by Dr. William Lamers, MD. This illustration can serve as a map for grievers. Obershaw (1992) notes that the circle takes the shape of a circle that does not close on itself. This type of circle represents to grieving people that emotions and behaviors during times of loss are closely connected. The inner circle represents words that describe feelings as a result of loss. The outer circle illustrates behaviors illustrated as a result of feelings (Obershaw, 1992).

Figure 1

Sequential Reactions to Loss by Dr. William Lamers, M.D.



Despite the fact that the stage models of grief have been used extensively, they may not address individual differences and other variables that can affect passage through the stages of grief. Worden (1991) was critical of the stage models of grief indicating that individuals do not always progress through the grieving process in an orderly fashion and may experience more than one stage at a time. Both professional clinicians and clients may take the stages too literally and inappropriately judge deflections from the model as pathological. Worden (1991) also believed that the stage model implies passivity, an inactive role in which the griever passes through something. Worden's task model is similar to the concept of grief work through its implication that the mourner should take some action. It empowers bereaved people by giving them a task to achieve.

Several writers have argued that the stage model does not indicate how much time lapses before an individual recovers from loss (Bornstein & Clayton, 1972; Davidson, 1979; Silver & Wortman, 1980). Charmaz (1980) contends that the stages of dying may not reflect the sequence of the patient's reactions to death but instead may be a response to institutional demands, staff needs or cultural values.

In spite of criticisms of the stage versus task theory of bereavement, an overlap of models appears to be present. Both the stage and task model requires that the bereaved person either consciously or unconsciously, moves around from one stage to another (McNeil, 1995).

Variations on grief

In the past thirty years there have been a multitude of books about death and dying. The books range from psychological, social and medical analysis to popular how-to-deal with death manuals (Hawkins, 1991).

Grief is a highly unique and individual process (Bowman, 1993; Doka, 1993; Parkes, 1975). No one experiences or copes with loss in the same way. Each person

responds very individually to loss. Grief responses can be affected by the result of many factors including: nature of attachment, mode of death, personality variables, history of losses, social variables and life changing events (Bowman, 1993; Worden, 1991). Doka (1996) further includes: psychological aspects of the bereaved including their grieving styles and coping strengths, the availability of social support, cultural and spiritual factors, and the presence of concurrent crises and stressors.

Grief is one of our most common of life experiences. When we experience separations, endings, or major changes, it is normal and appropriate for us to react with confusion, ambivalence, and a sense of loss. Grief is a part of life, (Bowman, 1993). Rando (1993) defined the words "bereave" and "rob" derive from the same root, which implies deprivation of something valued.

Complicated mourning

Defining complicated mourning has been difficult over history. The principal reason is the inconsistency of terminology used to define complicated mourning. "The identical grief and mourning have been described at various times by various authors as " pathological," " neurotic," " maladaptive," "unresolved," "abnormal," "dysfunctional," or "deviant" just to name a few of the designated terms," (Rando, 1993, p.45). The preference by Rando (1993) for the term "complicated mourning" suggests that mourning is a series of processes which in some way has become complicated with the implication being that what has become complicated can be uncomplicated and avoids negative connotations of many other terms and does not imply a pathology in the mourner (Rando, 1993)

Posttraumatic stress disorder (PTSD), although not considered a theory or model of grief is being discussed in the grief literature more frequently. The DSM-IV (American Psychiatric Association, 1994) states that a diagnosis of PTSD is indicated if a person has experienced an event that is outside the range of usual human experiences and that would

be markedly distressing to almost anyone. Loss and grief are likely to be greatly affected by the mode of death or loss. Efforts are currently being made to include PTSD as a bereavement model (Sprang, 1991).

Rando (1993) provides a useful description of the symptoms of complicated mourning that is strikingly similar to the description of PTSD:

> ...the grief symptomology persists much longer than usual, and mourners typically remain socially withdrawn, developing a sense of the deceased's continued presence. This binds them to the deceased and hampers their ability to function socially and occupationally (p. 175).

Rando (1993) further suggests that there are five types of death that are highly associated with complicated mourning. Among them are such traumatic circumstances as sudden, unexpected and traumatic circumstances; death of a child; and preventable death.

Grief following sudden or traumatic death

The effect of sudden death occurs when the bereaved did not have time to prepare for the death of go through a period of anticipatory grief. Rosen (1990) postulates three general categories of sudden death:

1. fatal medical events, such as heart attack, stroke, or death during routine surgery
2. accidental deaths, such as random accidents or catastrophic events as a natural disaster
3. suicide.

A conceivable fourth category might include violent death such as homicide or death by a drunk driver (McNeil, 1995).

Finally, an additional type of sudden loss that has received the least attention in terms of grief response is that of violence and urban children. Children may lose a parent, sibling, or significant other and are often expected to continue life as if nothing has happened (McNeil, 1995) As a result, the grief may be internalized or expressed through

disruptive school behavior, poor academic achievement, or acting out behavior. Doherty (1990) referred to a study of 52 children who had witnessed a murder of a parent. Many of these children suffered severe emotional and learning problems, including depression, short attention spans, violent behavior, nightmare, and memory loss. The tendency for many people is to ignore these deaths, stigmatize or disenfranchising the grievers (Doka, 1996, McNeil, 1995).

Anticipatory grief

In the anticipation of a future loss a form of normal grief can occur. Anticipatory grief includes many of the symptoms and processes of grief following a loss. Dying patients experience anticipatory grief but the term is most often used when discussing the families of the terminally ill. Anticipatory grief may occur in advance of losses other than death. For example, the patient who is to have a leg amputation, or a woman anticipating mastectomy surgery for breast cancer (Rando, 1983).

Disenfranchised grief

Grieving can be particularly difficult when losses are disenfranchised (Doka, 1989). Disenfranchised grief is grief that cannot be openly acknowledged, socially shared, or publicly supported. In some cases grief is disenfranchised because others do not recognize the relationship. For example, friends, lovers, ex-spouses, or caregivers can experience deep grief that others do not acknowledge. Doka (1989) also includes the loss of companion animals as well as psychosocial grief that can occur as a result of chronic and debilitating diseases such as Alzheimer's Disease and other irreversible medical conditions. Friends as grievers and employee grief is addressed. Disenfranchised divorce as grief is acknowledged. Grief can be disenfranchised when losses such as perinatal loss (i.e.: miscarriage, ectopic pregnancies, abortions) go unrecognized. Sometimes certain grievers, such as the very young, the very old, or the developmentally disabled, may not be

perceived as capable of grief. Certain types of grief such as death by AIDS-related causes or suicide can carry such social stigma that survivors are reluctant to share their loss with others. In many cases of disenfranchised grief the grief process is complicated, but the many supports available to other grievers are absent (Doka, 1989).

Children's Grief

Children, as with adults, are concerned about death and dying. Young people in the United States are among the disenfranchised griever of today's society (Ellis, 1989). The reported observations of parents, teachers, mental health professionals, healthcare professionals, funeral directors, and writers clearly indicate that the significant adults in the lives of young people tend to exclude them from participation in the rituals of family burial and grieving (Ellis, 1989).

There are differences in opinion about what constitutes grief reactions, grief and mourning in childhood. Major arguments come from proponents of psychoanalytic, developmental and cognitive views. When the child's grief is disenfranchised; there is potential consequences for those who carry unresolved childhood grief into adulthood. By some definitions of grief and mourning, young people as young as six months of age are capable of experiencing grief (Ellis, 1989).

The outcome of grief is less predictable for young people and may be more emotionally stifling because a child is building a foundation for growth and development (Schultz, 1985). Many children and adolescents, after the death of a parent, grandparent, sibling, relative, or friend, show signs of peer problems, unwillingness to remain in school, unreasonable withdrawal, anger, depression, suicide attempts, juvenile delinquency, increased alcohol and chemical use, inability to communicate, clinging to adults, nightmares, guilt, and aggressiveness (Siegal, 1985; Gyulay, 1975; Wass, 1985).

Children who are in deep grief for any length of time can experience a severe emotional impact which could slow their development and adjustment. Despite conflicting research, the literature abundantly documents the problems children have as adults when they have not successfully mourned (Gelcer, 1983, Parker & Manicavasagar, 1986).

Children can become more recognized as grievers. Adults can become better informed about the nature of grief, how different factors can impact the grief process and reactions. Adults can become better prepared to help children with their grief. As Wolff (1969) suggested, " Only when parents are helped to master their own often conflicting feelings in the face of death will they be able to adopt realistic and helpful attitudes towards their children" (p.75).

Corr (1984) believes that adults may need to make special efforts to help children cope with death. This involves accepting certain responsibilities such as: undertaking preparation by initiating a reflective analysis of their own thoughts and feelings about death by becoming familiar with basic principles of knowledge of grief and death; responding to the real needs in children; communicating effectively; and working cooperatively with children, other adults and relevant institutions in society (Corr et al, 1997)

Loss of dreams

Finally, Ted Bowman (1993) discusses yet another special kind of grief, (a psychosocial/symbolic loss) as the "Loss of Dreams." The loss of dreams refers to experiences that do not easily fit into our common understanding of grief. It is not just the loss of health, a relationship, life, or a job; it is also the loss of the imagined future, the loss of significant dreams (Bowman, 1993).

Personal Death Awareness for Medical Social Workers

The need for increased attention in the area of grief and death education for health care workers is substantially documented in the literature, (Brent, Speece, Gates, Mood & Kaul, 1991; Bendor, 1987; Dickenson, Sumner & Durand, 1987; Educational Work Group of the International work group on Death and Dying, 1991; Edmonds & Hooker, 1992; Finlay & Dallimore, 1991; Holman, 1990; Holmes-Garrett, 1986; Kingma, 1994; Lister & Gochros, 1976; MacDonald, 1994; Moore, 1984; Oakland, 1982; Rando, 1984; Shanfield, 1981; Tye, 1993; Warmbrod, 1986; Weinberg, 1985). Researchers in the areas of health care and social work have established a need for more holistic training noting the important dimension personal death awareness had for medical social workers (Holman, 1990; Holmes-Garrett,1986; Kingma, 1994; Lister & Gochros, 1976).

Over the years, society has institutionalized the dying process, depriving many people first-hand experience with death (Brent et al; 1991; Holman, 1990; Lister & Gochros, Dickenson, Sumner, & Durand, 1987). "Most dying occurs 'off stage' today in hospitals and nursing homes" (Dickenson, Sumner, & Durand, 1987). Medical advances have created opportunities for many ill and suffering people to have their process of death and dying become a highly technological and impersonal experience (Holman, 1990). Many social workers today work in medical or healthcare settings. For this reason, social workers should be prepared to cope with dying patients and their families by improving communication skills, acquiring assessment and intervention skills, and by reducing their own death anxiety.

Larson (1993) speaks to the altruism and empathy in our helping relationships:

"In the realm of caregiving, this kind of expanded empathy begins an acceptance of our own vulnerability and losses and can grow to include compassion for the pain of all human beings. There are no shortcuts, no pain-free ways to do this. We must look into

ourselves to learn to trust our common humanity. If we can do this, then our empathy will become a strong force in the world." (p.238)

Social work interventions with grief

Specht and Craig (1982) define social work as a "a profession with a dual purpose: to assist individuals and groups whose needs are not adequately met and to help change institutions so that they are more responsive to individual and group needs," (p.11). "People Caring for People", a directory publication by HCMC describes social workers as those who provide grief and loss counseling among other duties. Awareness of this mission provides motivation to become more responsive to patients and families at HCMC.

Modern social work values are characterized by a holistic ecological perspective that views people and the social environment as constantly influencing one another. Social work is concerned with the whole person as a mixture of spiritual, emotional and physical needs all dependent on each other (MacDonald, 1991).

The unfamiliarity with the death process means many people will not have developed necessary communication skills for dealing with dying patients or their families (Lister & Gochros, 1976). However, medical technology has now added to the longevity of people and the prolongation of dying and more attention is now being paid to the final stages of life (Lister & Gochros, 1976). Death has always been associated with negativity and something frightening (Kubler-Ross, 1969).

In recent decades, both the reduced number of deaths among young people and the increasing institutionalization of the dying process have isolated the death process even further from everyday life of the young. As a result, many people now reach early adulthood before they have had any direct contact with a dying person or have experienced the death of someone close to them (Brent et al., 1991).

Health care professionals are survivors of many and multidimensional losses during the course of their work (Shanfield, 1981). The themes of loss, death, responsibility for

life and death, and mourning are dominant in the lives of health care professionals, and the medical social worker is not exempt from these themes.

Two of the major goals of social work intervention in hospital based practice are to help patients and their families cope with the physical and emotional trauma that brought them there and to assist them in making those decisions and adaptations that will allow them to master illness rather than be destroyed by it. Mastery does not mean preventing death, as this is an inevitable reality for many patients (MacDonald, 1991).

Medical social workers bring the value of recognizing the patient's sense of self-determination and autonomy. Medical workers deal with many situations of life and death and with overwhelming problems which often have no medical or social solutions (Bendor, 1988).

The fear of death resides within all people (Feldman, 1987). Most have been able to achieve a degree of control over their destiny and it has become easier to deny basic vulnerability against diseases. The reality of death has become more difficult for Americans to deal with than it is for members of less developed societies who are constantly reminded of their helplessness in the face of threats of nature (Feldman, 1987).

According to Worden (1991) the experience of bereavement in others touches us personally in at least three ways while working with grievers. First, it makes us aware of our own losses, especially if the loss experience is similar to losses that we have sustained in our own lives. Loss that is not resolved in the social worker's life, can interfere a meaningful and helpful interaction. However, if the social worker has found resolution, this can be helpful to the interaction. A second area where grief may get in the way is in terms of the social worker's own feared losses. The third area in which grief intervention may present a special challenge to the social worker has to do with the existential anxiety of the social worker's own personal death awareness (Worden, 1991).

Social workers working with survivors of loss from death need to educate themselves on the particular problems of the different losses (Doka, 1996). This knowledge can help as they advocate for patients and explore or validate their responses. Each survivor will react and cope in his or her own unique way.

Finally, social workers connect patients and families to appropriate resources. The energy of these individuals is often spent just when they need to coordinate home health care or social services referrals. Lynch (1979) identified eight areas that social workers should consider as focuses for interventions with patients faced with terminal illnesses: (1) normal patterns of family communication and how these patterns change under stress, (2) the patient's potential for committing suicide, (3) alcohol abuse by the patient or primary caregiver, (4) persistent anxiety experienced by the patient and family, (5) care of the patient's children, grandchildren, parents or grandparents, (6) sexuality, (7) consultation with other healthcare professionals, (8) racial, cultural, and ethnic issues and how they may affect the patient's response to illness and death (Lynch, 1979).

Death education models

Corr (1992) states there is a pressing need to develop new and better theoretical models for explicating coping with dying. Corr believes that theoretical models for coping with dying should do four things; provide a basis for understanding all the dimensions and all the individuals that are involved; the second is to foster empowerment; third, to emphasize participation; and fourth, to provide guidance for care providers and helpers (Corr, 1992).

The education work group of the International Work Group on Death, Dying, and Bereavement (1991) established a statement of assumptions and principles regarding education about death, dying and bereavement. These assumptions and principles are intended to aid non-professionals and volunteers. This education can be applied to a wide range of loss experiences. This information can be applied and adapted to medical social

workers, mental health professionals, and hospice volunteers to name a few. "Education about death, dying and bereavement should be based on the current state of knowledge from a variety of disciplines, integrate theory and practice...." "Education about death and dying, and bereavement should enhance the ability of professionals to identify and meet their own needs, and provide an awareness of resources available to professionals for their own use" (Education Work Group on Death, Dying and Bereavement, 1991, p. 236-237).

Lister and Gochras (1976), developed a course for social workers on death. They have an informational component, experiential component and encouraged the sharing of personal experiences. The design of this course emphasized that effective practice in these areas required not only knowledge of the problems associated with dying but also skill and sufficient comfort to extend appropriate help.

Thorton, (1991), points out that, personal involvement is an important component in effectively teaching death and dying. When doing education regarding death and dying, many emotions and personal experiences will be evoked by trainees. Death education needs to have time built into the program for processing the feelings of trainees.

Literature Summary

The theories presented all represent a perception that grief is not static but rather a process leading to resolution of the intense emotional pain and suffering associated with grief and death. The reviewed literature supports the idea that medical social workers can benefit both themselves and their patients by participating in death awareness - grief education seminars.

The literature is clear there is a need for medical social work education in death and grief to more effectively serve patients and families. The research further identified significant literature supporting the need for social workers to be aware of their own comfort level with death-related experiences.

Medical social workers in clinics and hospitals are continuously confronted with death and loss encounters. The hospitalization of a person can evoke strong emotions about their own mortality and fear of the unknown. Research shows that bereaved people make more use of medical resources than nonbereaved people (Weinberg, 1985). Corr (1992) developed a task-based approach to coping with dying which contributes to improved understanding, empowerment, participation, and guidance for helpers. The use of this holistic perspective can be applied universally to all human beings and uniquely to each individual and recognized coping by all individuals involved in a particular experience of dying.

Most of the literature reviewed noted that a major issue is the strong and lasting effect of a death experience for an individual. Grief intervention and awareness is concerned with thinking through a loss, facing its reality, expressing feelings and emotions experienced and reorganizing life into different patterns.

This particular study addresses the effects of an experiential grief seminar for medical social workers and evaluates the participants' ability to connect theory with practical social work interventions, while confronting their own personal grief and death awareness. Chapter three will discuss the methodology and research study design used in this research.

CHAPTER THREE: METHODOLOGY

Overview

This chapter discusses the rationale for this research design and data collection used to answer the research question. It provides operational definitions of key concepts and explains how participants were selected. A description of the questionnaire design, program evaluation and steps taken to protect human subjects is included. The data collection procedure is outlined and methods used for data analysis are discussed.

Research Design

The research was an exploratory descriptive study of a program design, implementation and evaluation. The study uses primarily qualitative data collection supported by quantitative data to answer the research question. The researcher used a survey research design method and designed a self-administered questionnaire and evaluation to gather data from the sample population. This design was selected because it offered anonymity and privacy to participants, encouraging uninhibited responses from participants. Additionally, the use of a self-administered questionnaire avoids interview bias. The research sought to answer the question: Are medical social workers better prepared to assess grief issues after participating in a grief education seminar? The questionnaire serves as a pretest to identify participants experiences in assessing grief issues prior to attending the grief education seminar. The program evaluation provides the posttest perceptions of the effectiveness of both the individual and program objectives which are used to answer the research question.

Research Question

Are medical social workers better prepared to assess grief issues after participating in a grief education seminar?

Key Variables, Terms and Definitions

The independent variable from the research question is, "participation in grief education seminar." The dependent variable is, "preparedness."

The key terms applied in this research are: assessment, medical social workers, grief, grief education seminar, perception of preparedness and medical setting.

Definition of terms:

Assessment; The medical social worker's process of gathering, determining the nature, cause, progress, and strengths of situations where individuals are faced with grief and acquiring an understanding of the situation and the ability to identify and provide appropriate resolution and resources.

Medical social workers; All people who hold a BSW or MSW from a school of social work who are employed part-time, full-time or as field work students with Hennepin County Medical Center Social Services Department.

Grief; A person's response to any loss that is perceived as emotionally significant.

Mourning; The social and cultural response to grief.

Bereavement; The state of having suffered a loss.

Grief education seminar; An all-day seminar, "The Grief Journey: Our Patients, Ourselves" was designed by this researcher and also utilized a variety of programs and workshops designed for topic of grief education and awareness. A program designed by L. Walton, (1994): "Its time to prepare: Death education for social workers" and T.

Van Beck's (1993) seminar: "The Ticking of the Clock and the Tolling of the Bells" was adapted in conjunction with models researched and adapted by this researcher. A resource packet comprised of an outline/agenda, worksheets, references and resources was distributed to participants. The dates of the seminar were January 23 and January 30, 1997, the hours were 8:30 a.m. until 4:00 p.m. The use of lecture, role plays, large and small group discussion, poetry and music were utilized. Three videos were shown: To Touch a Grieving Heart, It's in every one of us and A Family in Grief: The Ameche Story. The room was designed for participants' comfort with adequate tables and chairs. Breaks and Lunch were incorporated. Each seminar began with Group Agreements about the group norms for the day. The participants were provided with a consent form and a questionnaire at the beginning of the seminar and an evaluation and certificate of attendance at the seminar's completion.

Preparedness; Medical social workers self-report their ability to assess people's grief responses before and after exposure to a grief education seminar designed by the researcher and presented at HCMC.

Medical setting; Hennepin County Medical Center (a public teaching hospital in Minneapolis, Minnesota).

Study population/Sample selection

The data for subject selection was gathered through a single stage sample obtained from a list of medical social workers employed at HCMC Social Services Department. A letter granting permission to conduct this research was obtained from the Director of Social Services (see Appendix D). Several members of the target population invited their field work students to participate thus resulting in an accumulation of subjects known as snowball sampling (Rubin & Babble, 1993).

The study population included the individual participants who were both male and female registrants of a grief education seminar on January 23 and January 30, 1997. Thirty

five announcements and registration forms were distributed resulting in a response rate of 66%, three men and twenty women (n=23) participants signed consent agreements. The sampling design was a purposive or convenience sample of medical social workers at Hennepin County Medical Center Social Services Department which includes inpatient and outpatient services. The sampling frame was the list of registrants of the death education seminar described above.

Data Collection Instrument

Survey questions served as the pretest and posttest and focused on measuring levels of social workers' perception of their preparation to work with patients and families related to grief and death (self-report). These questionnaires and evaluations were protested with three peer medical social workers allowing the researcher to edit and clarify the survey times, therefore increasing face validity and enhancing the effectiveness of the questionnaire. The format of the questionnaire and program evaluation included Likert-type, forced choice and open ended (qualitative) questions for both the questionnaire and the program evaluation which was distributed upon completion of the seminar.

Data Collection

A group administered questionnaire was distributed to all medical social workers who agreed to participate in the grief education seminar. The questionnaire and evaluation measured medical social workers response to their perception of preparedness regarding grief education and past experiences. The questionnaire was administered prior to the commencement of the seminar and the evaluation was administered upon completion of the seminar. The purpose of this group -administered questionnaire was to determine if there was perceived improvement. Results of both the questionnaire and evaluation responses are compared (see appendices).

All medical social workers at HCMC received a cover letter, including a description of the program and a registration form. The subjects were given a specific time frame of

two weeks to complete and return the registration form to a Social Services secretary. Qualitative data was collected from actual participants of the grief education seminars. A coding system for relevant data was devised. Data was collected from the returned questionnaires and program evaluations.

Meaurement Issues

In this study there are two potential sources of measurement error, systematic error and random error. The first systematic error may have occurred in measuring what people think and collecting data on attitudes. Bias may have been involved in the data collection. Bias may have occurred by the way questions were worded in a way that predisposes them to answer they way we want them to (Rubin & Babbie, 1993). The second potential source of measurement error may have occurred in random error, for example respondents who had little or no familiarity with grief jargon may have not understood what they were being asked but not wishing to appear ignorant, they might answer yes or no at random, hence the risk of random error. Reliability does not ensure accuracy in this study, however an interobserver was used for this seminar. The face validity of this research was determined by subjective assessments made by the researcher and interobserver.

Data Analysis

The data was analyzed using both qualitative and quantitative methods. For open ended questions, the data was organized into categories, themes, ideas and patterns. This information was reported by using tables, graphs and charts to illustrate. For quantitative data, frequency distributions and percentages were presented in aggregate form; The data was computed using the Statistical Package for Social Sciences (SPSS) (Norusis, 1990).

Protection of Human Subjects

In order to assure and prevent harm to or violation of rights of any individual who was a subject in this study, this research was approved by Augsburg College Institutional Review Board Committee, IRB approval number 96-29-2 and Hennepin County Medical Center Human Subject Research Committee, IRB approval number 45 CFR 46.101#1.

Participation in this seminar was completely voluntary. Consent Agreement forms were signed by all participants and the investigator. To secure data collected throughout this research study, a self-addressed envelope was returned directly to this researcher and carefully kept in a locked file; only the researcher had access to these data.

Confidentiality was assured to all participants. The records of this study were kept private. In the final report of findings, information that could make it possible to identify any subject were not included.

The findings of this research were aggregated and shared with the HCMC Director of Social Services, HCMC Social Services staff, HCMC Staff Development Committee and HCMC Quality Management Committee.

Summary

This chapter described an exploratory descriptive study which utilized survey research design to gather both qualitative and quantitative data to answer the research question. Key terms used in the study were operationally defined, subject selection and instrument design were discussed. Chapter four will report the findings of this research study.

CHAPTER FOUR: FINDINGS

Overview

This chapter presents the study's findings as they relate to the research question: Are medical social workers better prepared to assess grief issues after participating in a grief education seminar? and the overall purpose of the study which was to implement and evaluate a grief education seminar. The data were analyzed corresponding with patterns and themes. The response rate of participants in the grief education seminar was 66% (23 out of 35). Two surveys were used in this study, a questionnaire containing demographic information and a program evaluation (see appendices A and B). A return rate of 100% was generated from 23 questionnaires and evaluations distributed to participants. Findings will first be presented illustrating participants' demographic information followed by the integration of both qualitative and quantitative data with a specific focus from findings on pre and post tests. In addition, there was content present that can guide future social work. Figures and tables which include charts and graphs are used to illustrate and present frequency distributions and percentages in aggregate form. The questionnaire (pretest findings) refer to "participants" in figures and tables. The program evaluation (posttest findings) refers to participants as "respondents" in figures and tables.

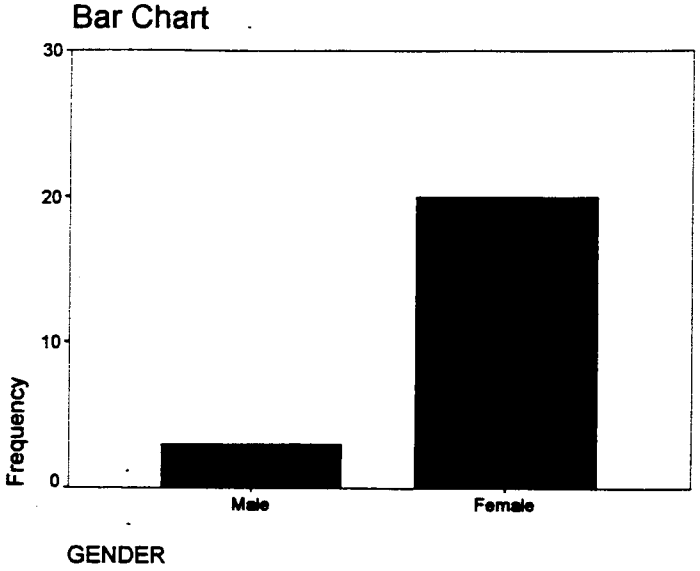
Questionnaire (Pretest Findings)

Background Information of Study Participants

Respondents were asked ten questions relevant to demographic information in an attempt to better describe and understand previous knowledge and loss experiences of participants of the seminar.

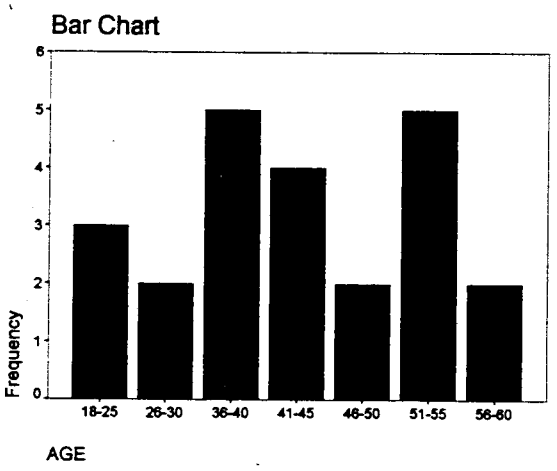
As you will see in Figure 2, Gender of Participants, the study was comprised of n=20, (87%) female respondents and n=3 , (13%) male respondents. See Figure 2.

Figure 2: Gender of Participants



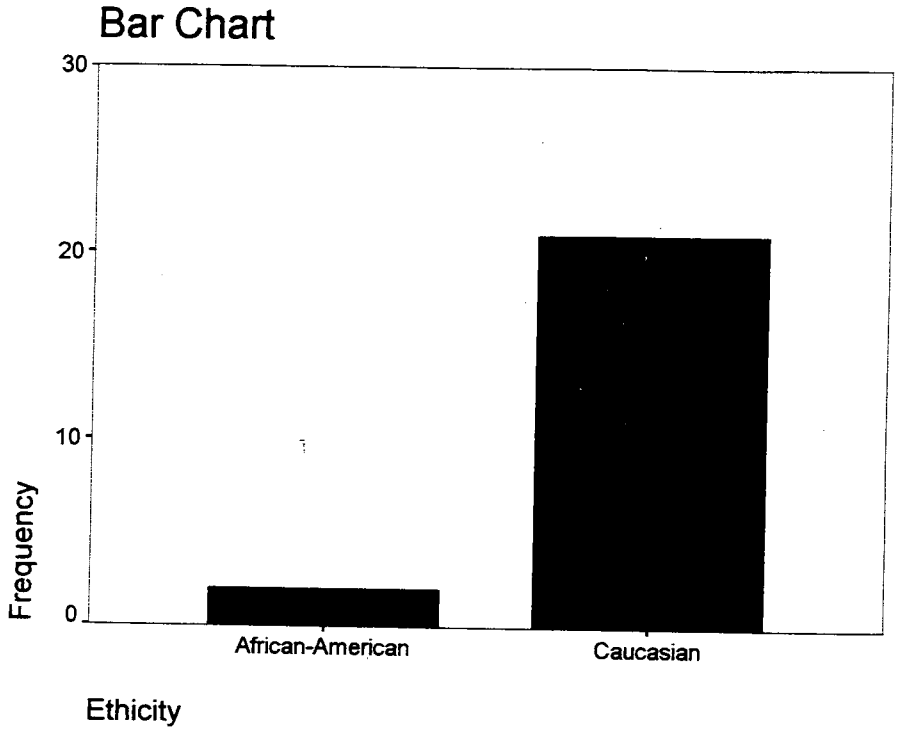
The respondents were asked to identify their age according to ten categories as illustrated in the corresponding chart. As illustrated below 13% were between the age of 18 125; 8.7% were between the ages of 26-30; 21.75% were between the ages of 36-40; 17.4% were between the ages of 41-45; 8.7% were between the ages of 46-50; 21% were between the ages 51-55; and 8.7% were between the ages 56-60. A fairly equal distribution of ages was represented. The age range was 18 to 60. The age ranges of 36-40 and 51-55 both had five respondents for equal representation for the mean age range. See Figure 3.

Figure 3: Age of Participants



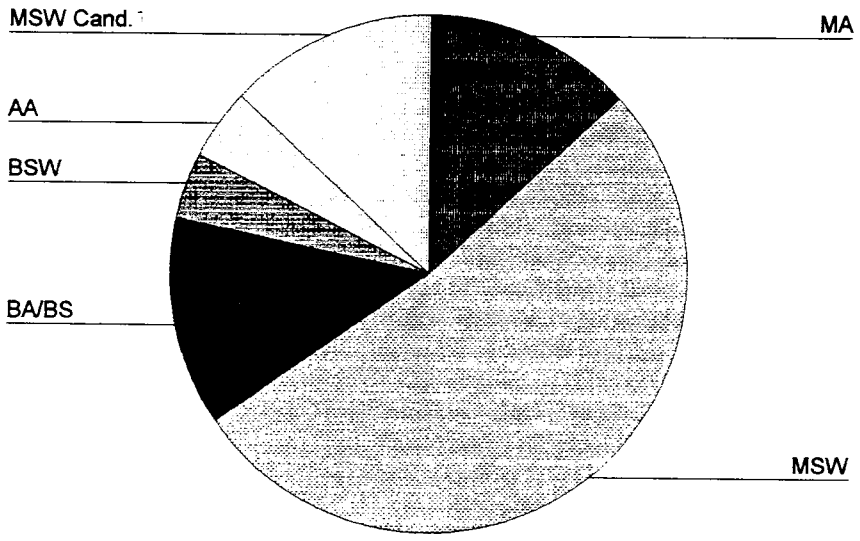
As figure 4: Ethnicity of Participants shows, the majority of participants n=21 (91.3%) were Caucasian and n=2 (8.7%) were African American. See Figure 4.

Figure 4: Ethnicity of Participants



As will be noticed in Figure 5: Education/Degree completed, the majority of respondents held Master of Social Work Degrees, n=12 (52.2%). Masters of Art degrees (MA) was the degree held by n=3 (13%) of respondents. Bachelor of Arts (BA) degrees or Bachelor of Science degrees were reported by n=3 (13%) of respondents. Bachelor of Science in Social Work (BSW) was held by n=1 respondent (4.3%) ; An Associate of Art (AA) degree was held by n=1(4.3%) ; and n=3 (13%) reported being in the process of Master of Social Work degree, labeled on the chart as MSW candidate. See Figure 5.

Figure 5: Educational Degrees of Participants



Participants' death experiences are depicted in Figure 6 and compares participants who have experienced the death of a close family member. The majority of participants n=17 (87%) reported yes and n=3 (13%) reported no. It is not surprising that most parcipants have backgrounds with personal loss experience, hence the interest in attending the grief seminar. See Figure 6.

Figure 6: Participants' death experience

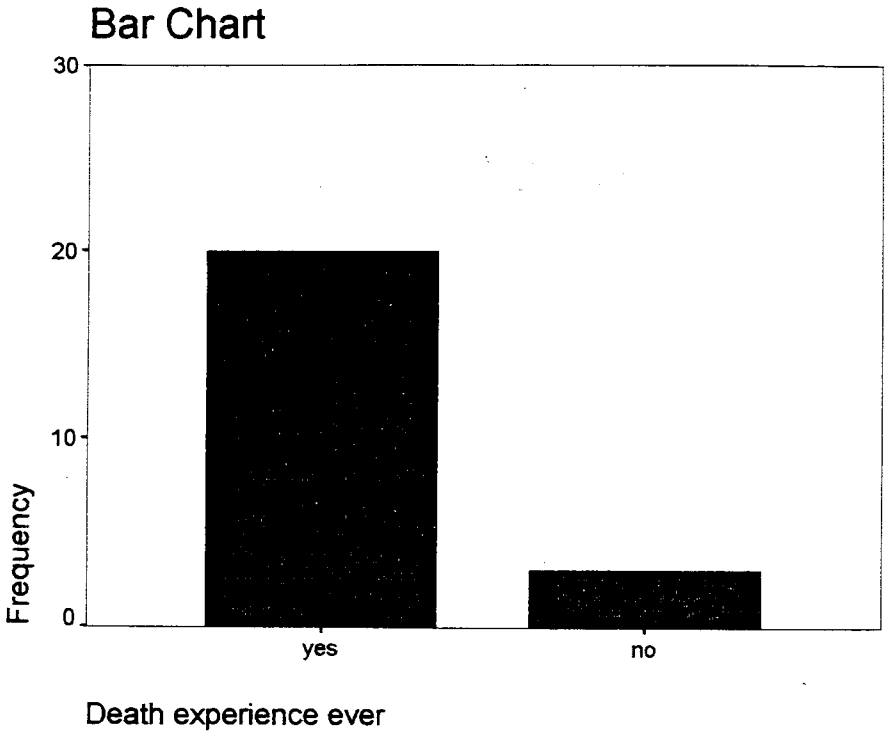
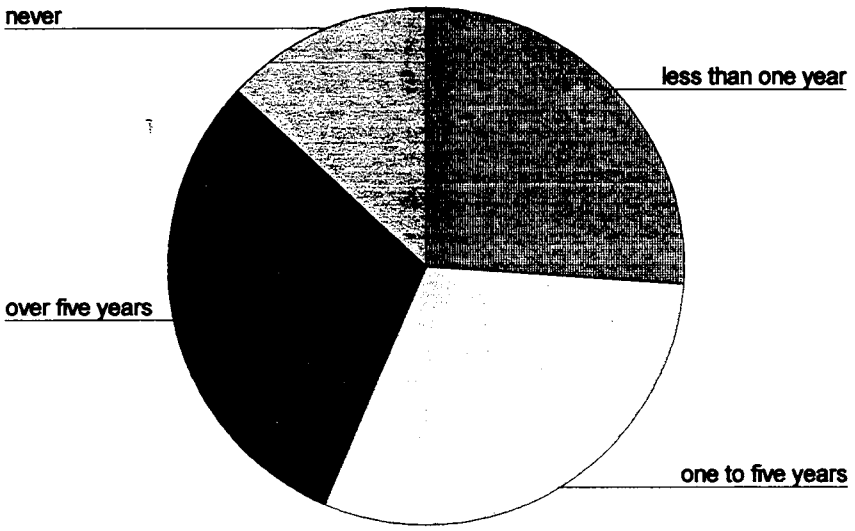


Figure 7 compares the Time since loss of family members reported by respondents. The loss ocuured less than one year ago for n=6 (26%) of respondents. The category one to five years ago was reported by n=7(30%). Over five years ago was reported n=7 (30%) respondents and no response was interpreted as never, n=3 (13%). See Figure 7.

Figure 7: Time Since Loss of Family Member



In Table 1: Participants' preparation to work with grief, respondents identify what preparation they have had that helps them to work with patients and families dealing with grief issues. Since respondents were given the opportunity to choose all that apply, the data exceeds 100%. Most respondents, n= 21 (91%) indicated life experiences and literature related to grief. Supervision related to grief was indicated by n=7 (35%); professional seminars on grief was the second highest category with n=18 (78%) respondents and college courses in grief was chosen by n=9 (39%) of respondents. See Table 1.

Table 1

Participants' preparation to work with grief

N=23

Study Population	Frequency	Percent
Life experiences	21	91%
Literature	21	91%
Supervision	7	35%
Prof.Seminars	18	78%
College Coursework in grief	9	39%

The category "other" generated the following responses:

Years of experience working with patients experiencing loss and grief

Religious training

Church

Trying to help others dealing with grief

Experience as a grief group facilitator, as a Hospice Director and Emergency Room Code Team member

Table 2: Participants' Assessment of Least Preparation shows areas they feel least prepared or uncomfortable in their work with grief. The most frequent response n=11 (48%) identified "closure" as the area of least comfort. "Initial Contact" n=4 was reported by 17% of respondents. "Understanding normal/pathological grief" was self assessed to be an area of least preparation for n=5 or (22%) of respondents. "Dealing with my own emotions" and "dealing with patient and family emotions" both were indicated by n=6, (26%) of respondents. See Table 2.

Table 2

Participants' self assessment of least prepared to work with grief

Study Population	Frequency	Percent
Crisis	9	39
Initial contact	4	17
Understanding normal/pathological grief	5	22
Dealing with my own emotions	6	26
Dealing with patients and families emotions	6	26
Closure	11	48

Other responses for feeling least prepared were given by three respondents, n=3, (13%) their comments: (1) *Invasion of privacy; (2) finding balance between being supportive and (3) intrusive and dealing with unexpected death.*

As illustrated in Table 3: Participants' Assessment of Most Preparation indicated which reactions they are most comfortable or most prepared to work with grief. Nearly all n=20 (87%) said "external sadness" is an emotion they are comfortable with. "Denial" n=4, (17%) was identified as the emotion less frequently identified as an area they felt prepared in their work. See Table 3.

Table 3

Participants' self assessment of most prepared to work with grief

Study Population	Frequency	Percent
Eternal sadness (crying)	20	87
Internal sadness (withdrawn)	8	35
Anger	10	44
Denial	4	17
Panic or emotional outbursts	8	35
Finding balance between being supportive and intrusive	8	35

Table 4: Participants' objectives for attending seminar will identify participants' own objective for attending the grief education seminar. As will be noticed, the response most often reported by participants was categorized as "increase knowledge of grief" n=19 (83%). Two other categories were identified as participants' objectives they are: "increase self awareness of own grief" and "overall framework for hospital work." The table below illustrates the frequency distributions which are extremely varied. Narrative responses illustrate the wide range of objectives more prominently. See Table 4.

Table 4

Respondents' objectives for attending grief education seminar

	N=23	
Study Population	Frequency	Percent
Increase knowledge of grief	19	83
Increase self awareness	3	13
Framework for hospital work with bereaved	1	4
n	23	100%

Individual objectives by respondents were:

To learn, to be able to pass on information and support others.

To become more aware of ways to help deal with grief.

Self investment - personal and professional; 100% of my patients will die prematurely.

I would like to be better prepared to deal with my own grief in the future.

New skills for supporting clients and dealing with my own issues.

To help parents grieve loss of dreams.

To recognize and help parents move toward closure.

To better understand the grief process, especially in crisis situations and in traumatic/unexpected death situations.

To get in touch with my own feelings about loss.

To learn more about the process of grief; consider my own grief responses.

To better understand how to deal with families dealing with the loss of a family member.

To increase my understanding of grief overall, to increase my comfort with varying expressions of grief by family and to become more in touch with my own areas of grief - unresolved feelings.

Program Evaluation (posttest findings)

The respondents provided the following data after participating in a one day grief education seminar: "The grief journey: Our patients, ourselves." Respondents were asked to rate the effectiveness of the seminar and provide recommendations and suggestions. Both quantitative and qualitative data are provided in figures and tables which include charts and graphs to illustate and present frequency distributions and percentages in aggregate form.

The primary purpose of the program evaluation was to provide meaningful feedback regarding the merit the seminar had for effecting perceived improvement by the medical social workers who answered the evaluation. Additionally, the program evaluation provides information for ways to improve the seminar.

Table 5: Respondents' rating of ability to meet own objectives for attending seminar illustrates respondents' degree to which they were able to meet their own objectives for attending the seminar. 56% rated meeting own objectives as outstanding and 44% gave it a rating of Good. See Table 5.

Table 5

Respondents' rating of ability to meet own objectives for attending seminar

Study Population	Frequency	Percent
	N=23	
Outstanding	13	56
Good	10	44
n	23	100

Table 6: Respondents' rating of relevance of seminar to social work practice examines respondents responses to the relevance of the content of the seminar to their social work practice. As noted, n=14 (60.9%) rated the relevance as outstanding; respondents rated the relevance as good n=8 (34.8%), and one respondent (4.3%) rated the relevance as satisfactory See Table 6.

Table 6

Respondents' rating of relevance of seminar to social work practice

Study Population	Frequency	Percent
	N=23	
Outstanding	14	60.9
Good	8	34.8
Satisfactory	1	4.3

As illustrated in Figures 8: Respondents' rating of identifying at least two grief theories, respondents answer the degree to which the content met the program objectives: 70% (n=16) rated their ability to identify at least two grief theories as outstanding; n=6 (26%) rated good; and 4% (n=1) rated this ability as satisfactory. See Figure 8. In Figure 9: Respondents' rating of awareness of own mortality, 65% (n=15) rated this as outstanding, 26% (n=6) rated it as good; 4% (n=1) rated satisfactory and 4% (n=10 rated their awareness of their own mortality as fair. See Figure 9. In Figure 10: Respondents' rating of informed of grief resources 56% (n=13) of respondents gave it an outstanding rating ; 26% (n=6) reported good; and 17% (n=4) rated their information about grief resources as satisfactory. See Figure 10.

Figure 8: Respondents' rating of identifying at least two grief theories

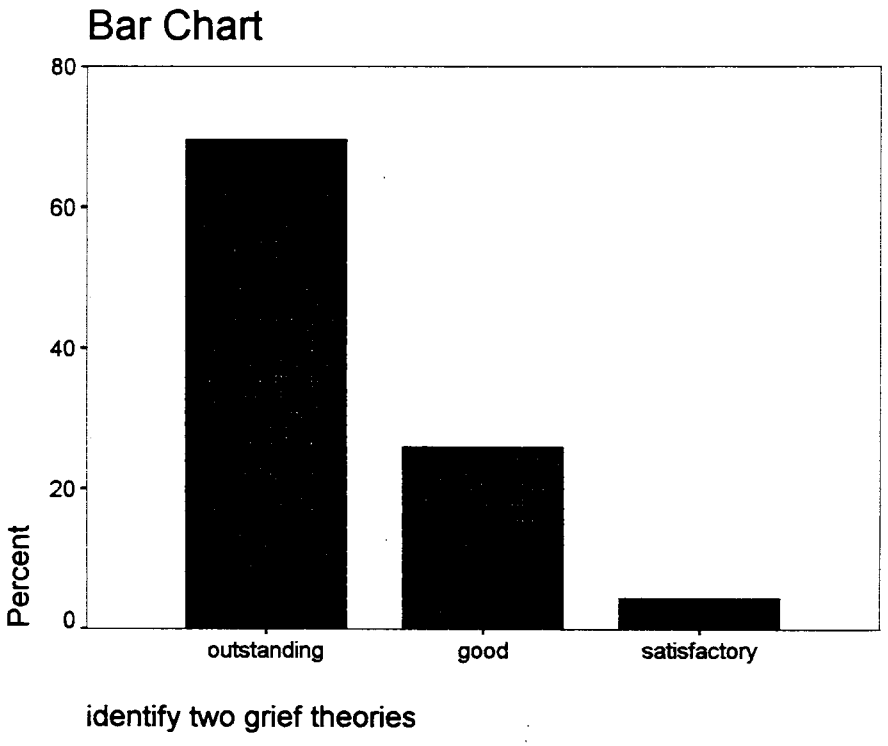


Figure 9: Respondents' rating of awareness of own mortality

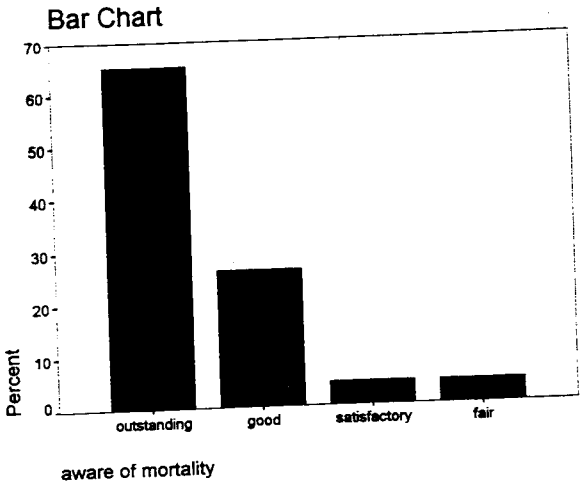
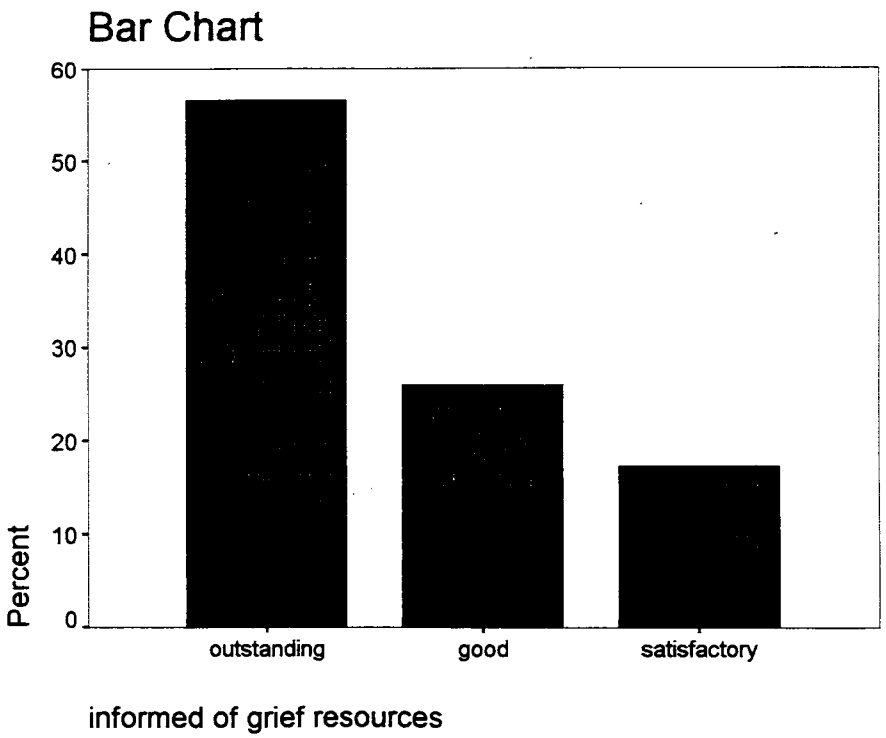


Figure 10: Respondents' rating of informed of grief resources



As Figure 11: Respondents' rating of presenter demonstrates, respondents rate the presentation/effectiveness of the presenter of the seminar. The majority of respondents n=18 (78.8%) rated the presentation effectiveness as outstanding; the second highest group, n=4 (17.4%) rated the presenter as good and 1 (4.3%) rated the presenter as satisfactory. See Figure 11.

Figure 11: Respondents' rating of presentation/effectiveness of presenter

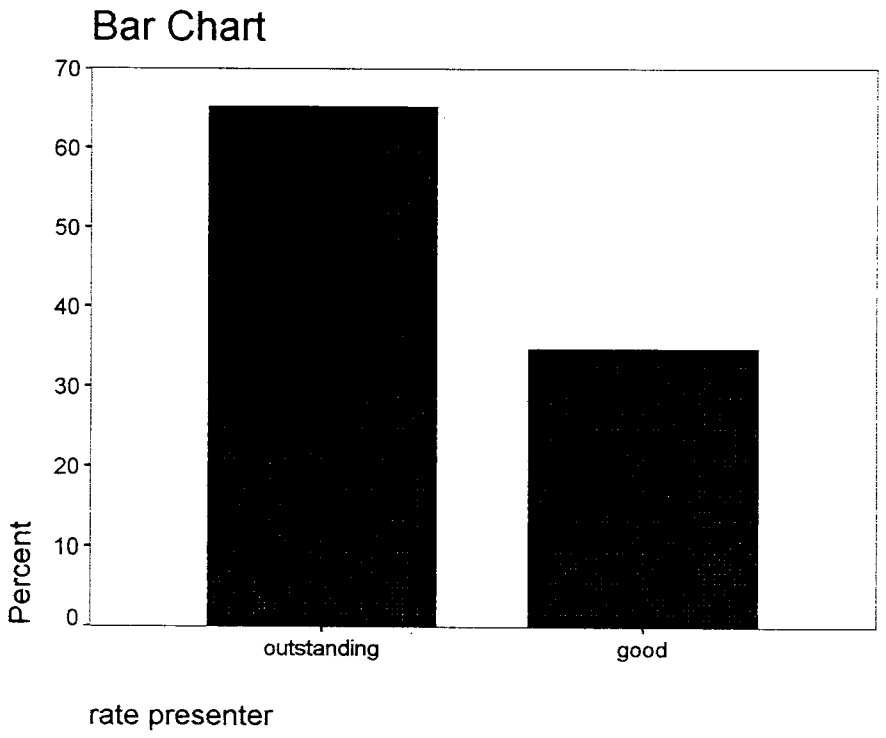


Figure 12: Respondents' rating of program outline and objectives illustrates the respondents ratings of program context. The respondents were asked to rate the program outline and objectives, n=14 (60.9%) rated the program objectives as outstanding, n=8 (34.8%) rated the program objectives as good, and n=1 (4.3%) rated the program objectives as satisfactory. See Figure 12.

Figure 12: Respondents' Rating of program outline and objectives

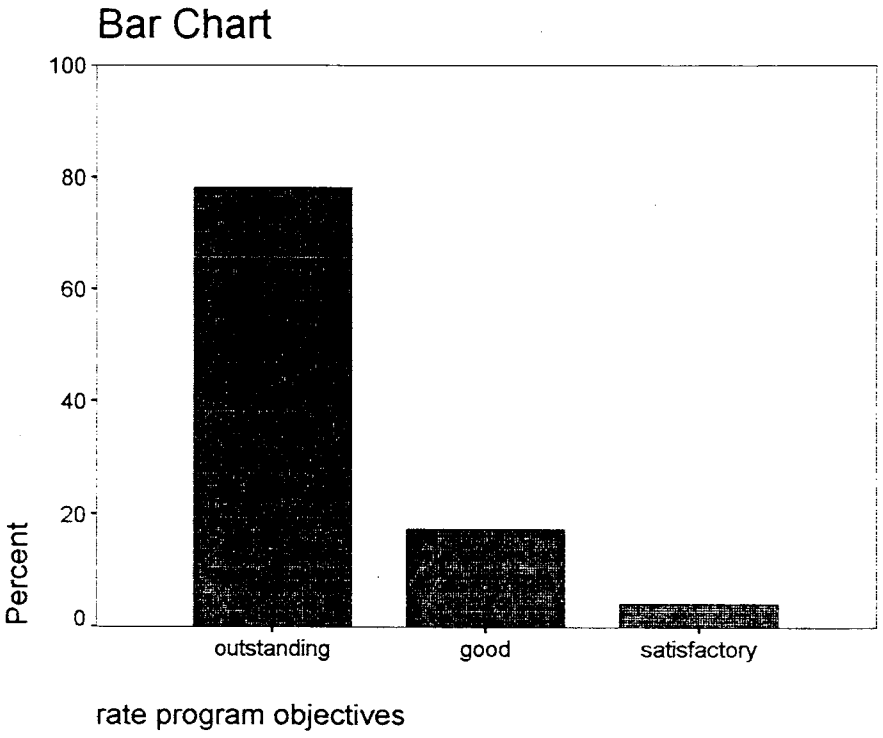


Table 7: Respondents' rating of videos illustrates respondents rating of the videos, n=14 (60.9%) rated the videos as outstanding, n=6(26.1%) rated the videos as good and n=3 (13%) rated them as satisfactory. See Table 7.

Table 7

Respondents' rating of videos

rate videos

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	outstanding	14	60.9	60.9	60.9
	good	6	26.1	26.1	87.0
	satisfactory	3	13.0	13.0	100.0
	Total	23	100.0	100.0	
Total		23	100.0		

Table 8: Respondents' rating of resource packet and references shows the respondents' rating of the resource packet and references used in the seminar. Outstanding was the rating given by n=14 (60/9%), Good was the rating given by n=8 (34.8%) and Satisfactory was the rating given by 1 respondent (4.3%). See Table 8.

Table 8

Respondents' rating of resource packet and references

rate resources

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	outstanding	14	60.9	60.9	60.9
	good	8	34.8	34.8	95.7
	satisfactory	1	4.3	4.3	100.0
	Total	23	100.0	100.0	
Total		23	100.0		

The respondents' rating of role plays and small groups is illustrated in Figure 13. As will be noticed, this was the least favorable rating of the program. Only 6 respondents (26%) rated role plays and small groups as outstanding, n=13 (56.5%) rated them as good, n=3 (13%) rated them as satisfactory, and one respondent (4.3%) rated them as poor. See Figure 13.

Figure 13: Respondents' rating of role plays and small groups

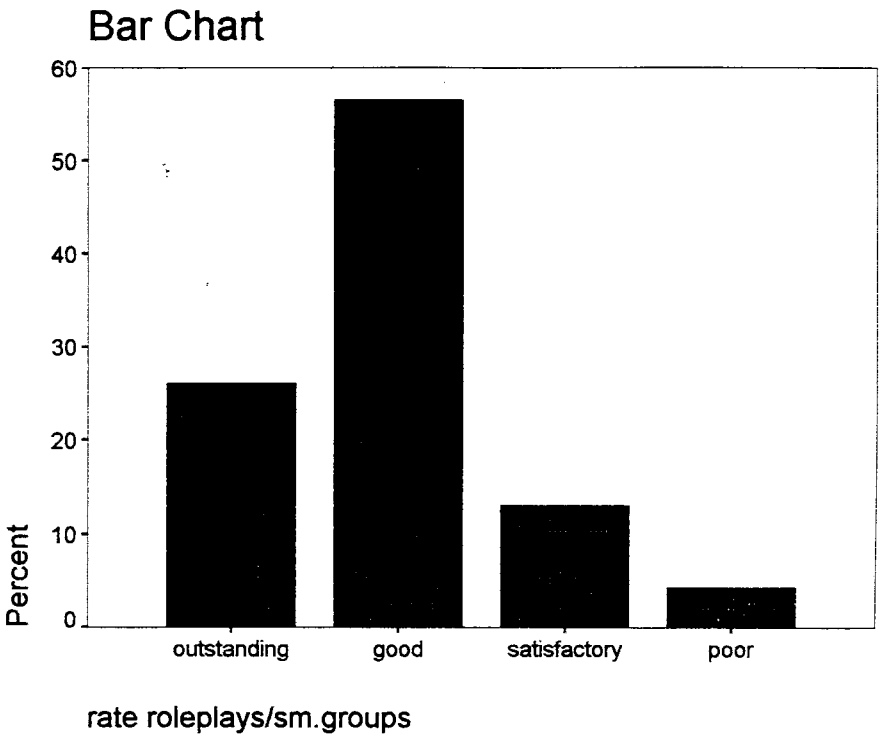


Figure 14 below reflects respondents' rating of lecture and large group discussions. The ratings were n=13 (56%) outstanding and n=10 (43.4%) stated the lecture and large group discussions were good. There was a more favorable response to large group discussions as compared to small group discussions which were depicted in the preceding figure. See Figure 14.

Figure 14: Respondents' rating of lecture and large group discussions

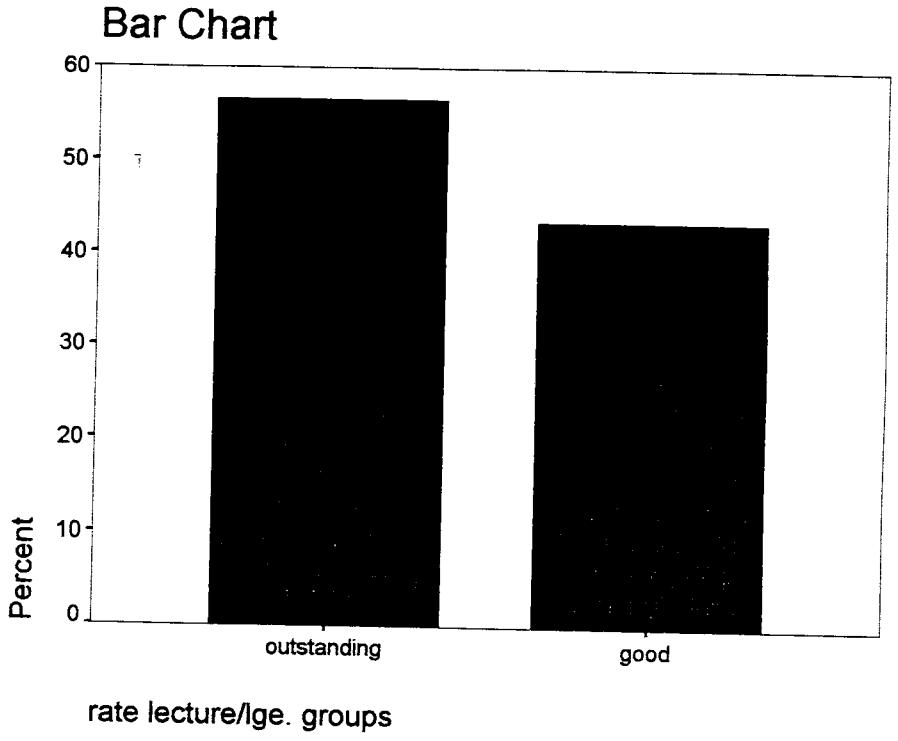
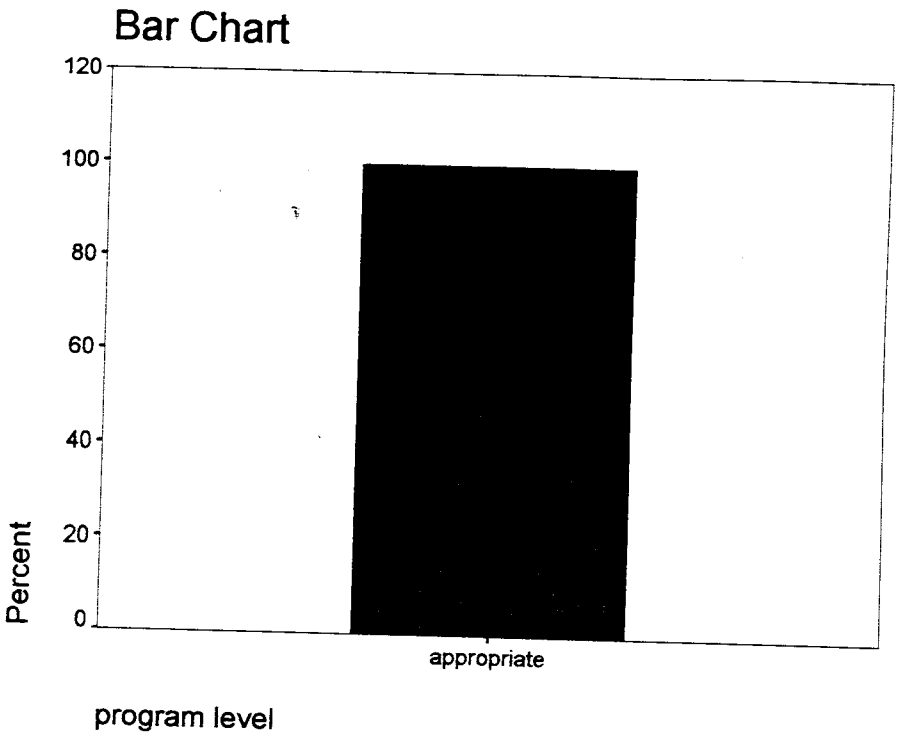


Figure 15: Respondents' rating of program level based on previous knowledge and experience shows respondents rating of the level of this program (seminar). All of the respondents, n=23 (100%) said the program was appropriate. The scale used to measure this response was (1=too basic) (2=appropriate) and (3=too complex). See Figure 15.

Figure 15: Respondents' rating of program level based on previous knowledge and experience



The final posttest evaluation question asked respondents to make suggestions, changes or additions they would recommend. A significant finding was that n=8 (35%) felt they needed more time for processing emotions and information, a comment summarizing this finding was: " too much material and too little time."

Several respondents offered comments and recommendations as follows:

Possibly other videos that represent how grieving can be different based on cultural perspectives. There is sameness in some ways relative to grief process but also differences.

Good to have a lot of discussion, that's usually what's most helpful

Might be trying to cover too many things - too many exercises.

Might not be enough time to process for some participants.

This is a tough one - its a lot of material and moves quick. Don't know what the solution is ' cause its all good. 2 days?

A little more silence to allow people to collect thought when in large group.

Sometimes it felt a little rushed.

I would like more suggestions for dealing with traumatic death and family's grief reactions on the spot.

Well organized, good handouts, good resource materials,

good food, good crying.

The following findings are reactions to a group exercise used in the seminar about personal grief and death awareness: "Getting in touch with our grief." The objective of this exercise was for participants to get in touch with their losses by means of recording the most important people and things in their life and how it feels when they are arbitrarily taken away from them.

In a large group participants discussed and compared the following comments as recorded by this researcher:

" Powerless. No control. Wanted to start bargaining. I was more okay when I lost things than kid/people losses. Shock hits you. Denial - a trick. I didn't know what was coming. [This exercise] put me in touch with my own aging, pain, loss. We are in for more loss - hits you. Acceptance/truth. Relief that it was just a group exercise. Losses vary person to person. The level of importance matters. Overwhelming. Force of emotion. Crazy. The superstitious part of me came out - we shouldn't tempt fate. I felt numb because the worst thing happened.

The following findings are narrative responses from the final group discussion: "Sharing our stories" and "This is why I do this moments." The following comments specifically relate to what makes their work most difficult working with grief and bereaved individuals and families; suggestions for social work empowerment and changes; and vividly illustrates meaningful exchanges and moments social workers have experienced in their work with grief:

Finding time and quiet

Disfigurement and Dementia

Dealing with the unfairness of life

To be supportive, yet not intrusive

The ability to not get our feelings mixed up with their needs

The surviving minor children

Fear of making follow up calls

The sad feeling evoked and 'I don't like that'"

Delivering grief packets when a death occurs feels "trivial"

100% of my patients will die prematurely

The following participant suggestions illustrate what social workers can do to better assess and intervene with patients and families experiencing grief and death issues:

Send a card to survivors following a death from HIV/AIDS

Self-care

Talking with peers, colleagues and friends

Debrief informally

Facilitate formal and informal debriefings (especially in the Intensive Care Units and Emergency Department

Establish protocols

Attending funerals for "closure"

Finding ways to deal with people who direct their anger toward social worker

The following narratives illustrate the participants' insight and reflections from both the seminar and their work with grief. These comments were written on index cards and shared in the final large group discussion and later given to the presenter at the conclusion of the seminar:

I realize the need to be there for others (after having gone through some crisis situations myself).

Grief work is a sacred journey, self care is very important so as not to add to their pain.

To be with them at this most sacred and precious time is a gift to me.

Helping people through difficult times and listening where there is no one else and making a connection to see and feel God.

Help people find a way to let go that is within a supportive, caring atmosphere and provide people with knowledge and empathy in making this difficult journey.

Iv always felt that the losses people experience from the time they hear they're HIV to death are much more difficult to me than the actual death. I work with them through those losses, to hopefully get to a point where they can grieve their illness and death.

To help others understand and realize they are not alone in their experience.

I would want someone there for ME. I'm glad to have had the opportunity to be there for YOU.

Why do I do this? I enjoy being with people during crisis - where there is opportunity for change. Giving people a chance to begin a process of exploration and reunite with another part that has been silenced"

The "Smith" family. After many years I saw the family in the waiting room and we sill felt a sense of having shared something important: the patient's death.

Because I know how powerful it is to simply be there.

I would not have the depth of empathy if I didn't go through it.

Bittersweet not bitter.

During funerals love is given freely and nothing is expected in return.

Rituals provide for remembering which leads to healing.

Summary

This chapter reported the findings of the pretest questionnaire and posttest evaluation. Both quantitative and qualitative data were presented to answer the research question. An example of responses to a group exercise used in the seminar was used to illustrate the depth of meaning the seminar had in preparing medical social workers to better assess grief while getting in touch with their own losses (personal death awareness). Narrative reflections illustrated participants' insights and meaningful experiences during the seminar and in their social work practice.

The next chapter will provide an analysis of the study's findings. Key findings will be discussed, comparison of findings to the literature review are included. Strengths and limitations of the study are examined and the relevance of findings to the research question are provided.

CHAPTER FIVE: ANALYSIS OF FINDINGS

Overview

This chapter discusses key findings as well as a comparison of the findings to the literature review. The strengths and limitations are presented in addition to the finding's relevance to the research question.

Key Findings

This study was an exploration of medical social workers participation in a grief education seminar. The results identified that participants were more aware of grief theories, more aware of their own mortality and more aware of grief resources. This evidence substantiates the premise that social workers are better prepared to assess patient and family grief after participating in a grief seminar designed exclusively for medical social workers. Participants overwhelmingly agree that the seminar met their objectives for attending the grief education seminar.

A significant finding is that diversity of age and education level encompassed from social workers in training to social workers with vast social work experience, yet all respondents agreed the level of the seminar was appropriate to their social work practice.

Another curious finding provided insight as to the motivation for attending the seminar. Most respondents n=20 (87%) reported that they had experienced the death of a close family member which may have contributed to their personal interest in the seminar. When participants were asked what area of working with grief they felt least prepared, the majority said dealing with crisis, closure, understanding normal and pathological grief and dealing with my own emotions as the most frequent responses. These areas were

substantially covered in the seminar with the exception of a formal presentation related to dealing with crisis.

The findings reveal that although the participants' objectives for attending were varied, the majority (78%) rated the program objectives as outstanding. On the other hand, only a few, n=7 respondents rated the role plays as outstanding, which could be indicative of the participants desire for self care and less interaction.

Overall, this seminar helped participants look face to face at their own mortality and of those they love while increasing their knowledge and intervention skills. This style of seminar about grief education will inevitably awaken old or unresolved grief and loss experiences, which leads to a sorting and resolution of feelings about these experiences. The seminar provided conceptual tools for dealing with and learning about their own personal grief awareness and emotional responses. However, a seminar cannot replace the depth of knowledge repeated clinical experience offers.

Comparison of Findings to Literature Review

The survey findings are consistent with the literature which indicates that no perfect theory for grief intervention can be generalized as each individual's loss situation will be unique and the interventions need to be used accordingly. The need for increased attention in the area of grief and death education for health care workers is substantially documented in the literature. As expected, less than half, n=9 (39%) of respondents had any college courseware in grief. Researchers in the areas of health care and social work have established a need form more training especially in the dimensions of personal death awareness. This finding concurs with several authors of empirical literature found in this literature review. Worden (1991) believes that loss that is not resolved in a social worker's life can interfere with meaningful and helpful interventions. However if the social worker has found resolution, this can be helpful.

Only one previous empirical research was found that included a design, implementation and evaluation of a grief education seminar. Moore (1994) designed a

program to help prepare social workers work with terminally ill patients and their families and to help them probe their own perspectives on death. Moore's findings included: providing training on patterns of communication, social work intervention, perspectives on data and a workshop evaluation. All participants agreed that the combination of lectures, role plays and experiential learning exercises were highly effective.

The gaps in the literature appear to be in the lack of documents written by and for social workers who work with grief, dying and death themes. There is limited current and empirical research with specific training programs designed exclusively for medical social workers. There is an abundance of literature illustrating the need for death education for health care professionals and mental health practitioners. Much of the literature examined in this research was found in journals of psychiatry, social science, and nursing education. Each individual's loss situation will be unique and the social work interventions will need to be addressed accordingly; there will be no perfect theory that can be generalized. There appears to be a need for further research in the area of identifying problems related to complicated mourning (Rando,1993).

Recently, the positive effects of crisis have received an increasing amount of attention in the literature and are emerging as possible areas of personal growth, adult development and self-transformation (Edmonds & Hooker, 1992).

Strengths and Limitations

There are both strengths and limitations in this study. A major strength of this study is the integration of both qualitative nature of the design as well as the quantitative data analysis. Qualitative data provided richness of personal reflections to the data. The strength of quantitative data is that it numerically describes and explains the phenomena reflected in their responses.

Another strength of this study is that it is exploratory research that accomplished what it set out to do: to provide an overview of grief, to explore participants personal losses and to help participants get in touch with grief through experiential learning. An

unexpected outcome came from one of the participants who indicated she found a sense of comfort in dealing with unresolved grief issues.

An additional strength was that providing social workers with valuable insight into themselves as well as grief and death education which minimizes the need for trial and error while working with patients and families. The information provided at the seminar can be powerful assessment tools.

Since social work practice is based on knowledge of human behavior and conscious use of self, this study can have immediate practical use. Social workers who offer meaningful support and empathetic listening are among the most helpful interventions.

There were several limitations to this study. The generalizability (external validity) of this study cannot be generalized to the field of social work as the results do not necessarily represent all medical social workers; However, characteristics of qualitative data validity is established through a triangulation of sources of data. This study omits individuals who either chose not to or were unable to participate in the seminar. The sample size was small, n=23.

Another limitation of this study involves responder bias. The questionnaire was self-reported data rather than observed behavioral interaction data and measures only perceptions of the sample. The expectation for qualitative research is that readers will make their own interpretation of the generalizability of the study to their own professional work. The information is relevant to the field of social work but is limited to a specific population. Finally, the questionnaire may have altered the way participants responded to the seminar.

Relevance to Research Question

The study used data to evaluate the preparedness of medical social workers in assessing grief after participating in a grief education seminar. The overall response to answer this question lies in the increased personal death awareness which leads to increased knowledge of how to assess grief responses in others. The inclusion of personal

involvement in this study was an important component in effectively measuring and evaluating the effectiveness of participants' perception of improved preparedness.

The finding as they relate to the research question are based less on cause and effect but rather on perceptions of the study and are of value in providing insight and information to medical social workers in the following ways: by providing social workers with insight into their own mortality and grief response as well as information on grief theory, resources and social work interventions.

Summary

The results of the study offer information about medical social workers as credible resources in the areas of assessment, intervention and counseling patients and families in various stages of grief. Because staff participation was crucial to the program's success, it was important to recognize subjects' discomfort dealing with their own feelings and expressions of grief while enhancing their ability to assist patients struggling with loss. While grief is a complex, individual experience, implementing grief education seminars can have a positive effect on both medical social workers as well as patients and families. Clearly, the use of experiential learning enabled the participants to connect theory and learn practical applications and to confront concerns and feelings affecting their work with dying and bereaved.

Chapter six provides the study's conclusions which includes implications for social work practice, recommendations for policies and practice and suggestions for future research.

CHAPTER SIX: CONCLUSIONS & RECOMMENDATIONS

Implications for Practice and the Field of Social Work

Many social workers today work in medical or health care related settings. For this reason, social workers should be prepared to cope with dying patients and their families by improving communication skills, acquiring assessment and intervention skills, and through reducing their own death anxiety.

Medical social workers can benefit from grief education seminars and the open discussion of this emotionally sensitive topic. Social workers can become both more confident and better prepared to provide care and support to patients and families in the midst of grief. Social workers must be able to offer an open invitation to patients to discuss their grief and to listen willingly and respond appropriately. Having an educated and sensitive social service staff can alleviate the helpless experience that can be associated with the end of life for patients and families served in the medical setting.

This study offers the field of social work an expansion of resources and knowledge for the researcher as well as future social workers. This research contributes to grief education and personal death awareness in addition to providing social workers a rare experience to share their common humanity. Through in-service seminars and peer consultation, social workers can educate other social work practitioners about the needs of people to do grief work and provide a safe environment to accommodate this process.

Recommendations for policies and practice

This study has implications for improving an awareness of family policy issues such as health care reform efforts. The commitment of social work to increase access, quality and equity in health and social work services can be an opportunity for this study. Given the awareness that persons over 65 are the fastest growing age in the nation will

place more demands on the health care system. The opportunity for medical social work to continue to take leadership in service to young and old is clear.

Results of this study can be useful in developing other programs in the field of social work and grief. There are opportunities for innovative programs in social work practice at the organizational, local, state and federal legislative levels. From an organizational perspective this study has opened the door for further exploration through continuing education and staff development for medical social workers.

This research has implications for affecting social workers outside of their immediate seminar group as they become additional key resources on grief, loss and death. Social workers can become better prepared to react to grief and death which requires open communication that supports both staff and patients in coping with the emotional stress brought on by death and loss experiences. Social workers have a role in advocating for grieving persons by developing protocols and strategies to influence the hospital environment. By including staff members in the program design, implementation and program evaluation, their feelings of investment in the grief education seminar may increase.

Suggestions for future research

This study could be expanded to include other healthcare professionals perceptions as well as patients and families. The questionnaire and program evaluations may want to specifically ask participants to what degree they were able to answer the research question and how relevant the content is to their practice. The pretest questionnaire could have included a reference as to how long it had been since they had experienced a loss in terms of their work with patients or clients. Further research may want to pretest for social workers' unresolved grief and it's impact upon their practice.

Future research may want to look at circumstances of biomedical ethics such as euthanasia, end of life decision -making, and the use of advance directives. Further research is suggested to explore gender differences as well as differences in racial and

ethnic groups. Issues related to lifespan variables is another area for further investigation. Ritual and funeral practices can be explored for the implications in both the grief process and grief resolution. The effects of trauma, violence, and homicide need further research. Research related to the presence of concurrent support and/stressors of the participants may be suggested. Social workers' awareness of stress reactions and burnout is another area of further exploration.

Research is important to the future of social work practice in a medical setting and will need to look at future development of case management, increasing skills in the area of working with patients with chronic and terminal illnesses. Despite reasons for a lack of social work courses in death and dying, this study and the research proves this to be beneficial to both patients and social workers. Social work professionals and students need to advocate for death awareness courses to be included in the Council on Social Work Education curriculum. The lack of grief and death education is particularly distressing because medical social workers most often have the greatest contact with dying patients and grieving family members. Social workers who believe in the benefits of death education should promote this belief.

A growing number of bereavement theorists have discussed working through grief as a process of searching for and finding meaning in the loss experience. There is a need for further research in the area of correlating the resolution of grief and growth promoting changes in the bereaved individual.

Summary

This study has contributed to filling the gap of experiential grief and death education specific to medical social workers. It is the researchers hope that the recommendations and suggestions for seminar improvements made by participants of this study lead to future research. A future researcher may want to implement a grief education series several days designed for medical social work staff or health care professionals which would allow

more time for processing and reflection. The results suggest that training and experience were both essential elements in feeling adequately prepared to work with grief and loss.

The theories of Kubler-Ross, Worden and Rando were introduced as a framework for grief interventions and assessment tools for preparing social workers to become better prepared to assess patient and family grief responses. The study also highlights the need for social workers to begin to address their fears about death and facing their own mortality.

Finally, it is the researcher's goal that the study motivates other social workers, professionals in healthcare and social work educators to continue efforts to meet the bereavement related needs of patients and social workers. The researcher will continue offering the seminar program: "The grief journey: our patients, ourselves" to other medical and mental health care professionals. Both patients and social workers benefit from the enhanced awareness and skill the seminar described in this study provides.

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APPENDICES

Appendix A

MEDICAL SOCIAL WORKER'S GRIEF SEMINAR QUESTIONNAIRE

Thank you for agreeing to participate in this research about your perception of grief and death.

Please answer the following questions by placing an X next to the appropriate answer.

Demographic Information:

1. SEX

_____Male

_____Female

2. AGE

____18-25 ____31-35 ____41-45 ____51-55 ____61-65

____26-30 ____36-40 ____46-50 ____56-60 ____65+

3. ETHNICITY

____African American

____Asian/Pacific

____Caucasian

____Hispanic/Latino

____Native American

____Other_____

4. EDUCATION COMPLETED

____College Degree (SPECIFY MAJOR)_____

____Graduate Degree(s) (SPECIFY MAJOR)_____

GRIEF/DEATH AWARENESS

It is well known that our grief experiences affect us in our professional work. The themes of loss, death, responsibility for life and death, and mourning are dominant in the lives of medical social workers. With this in mind, please answer the following questions.

5. Have you experienced the death of a close family member in the past year?

____Yes
____No

____Specify

5. Have you ever experienced the death of a close family member?

____Yes

____No

6. When did your loss of a close family member occur?

___One year ago or less

___1-5 years ago

___Over 5 years ago

7. What preparation have you had that helps you to work with patients and families dealing with grief issues?

____Life experiences

____Literature related to grief

____Supervision related to grief

____Professional seminars on grief

____College coursework in grief

____Other (please specify)_____

8. In what areas of this work with the bereaved do you feel least prepared or uncomfortable when meeting patients/families?

____Crisis

_____Initial contact/Assessment

____Understanding normal/pathological grief/mourning

____Dealing with my own emotional reactions

____Dealing with patients and families emotional reactions

____Closure

____Other (please specify)_____

9. Which reactions are you most comfortable with in working with the bereaved?

____External sadness (crying, direct expressions of sadness)

____Internal sadness (depression, quiet, withdrawn, silence)

____Anger

____Denial

____Panic reactions or emotional outbursts

____Finding appropriate balance between supportive & not being intrusive

____Other (please specify)_____

PLEASE ANSWER PRIOR TO PARTICIPATION IN SEMINAR

10. What are your objectives for attending today's seminar?

THANK YOU FOR YOUR PARTICIPATION!

Appendix B

THE GRIEF JOURNEY: OUR PATIENTS, OURSELVES
JANUARY 23, 1997
JANUARY 30, 1997

PROGRAM EVALUATION

To assist us in evaluating the effectiveness of this program and to make recommendations for future programs, please complete this evaluation by **circling** the appropriate rating.

(1= OUTSTANDING) (2=GOOD) (3=SATISFACTORY) (4=FAIR) (5=POOR)

1. To what degree did the content meet the program objectives?	1	2	3	4	5
a. I can identify at least two grief theories	1	2	3	4	5
b. I am more aware of my own mortality	1	2	3	4	5
c. I am informed of grief resources	1	2	3	4	5
2. To what degree were you able to meet your own objectives for attending?	1	2	3	4	5
3. How relevant was the content to your practice?	1	2	3	4	5
4. How would you rate the presentation/ effectiveness of today's presenters? Colleen Hoffman, LSW	1	2	3	4	5
5. How would you rate the following aspects of the program?					
a. Outline/ program objectives	1	2	3	4	5
b. Videos	1	2	3	4	5
c. Resource packet, references	1	2	3	4	5
d. Role-plays/small groups	1	2	3	4	5
e. Lecture/large group discussions	1	2	3	4	5

6. Based upon previous knowledge and experiences, the level of this program was:

(1=Too Basic) (2=Appropriate) (3=Too complex)

7. What suggestions/changes/additions would you recommend?

THANK YOU FOR YOUR VALUABLE INPUT!

Appendix C

HCMC IRB Approval #45 CFR 46.101#1
Augsburg College IRB Approval #96-29-2

Grief Education Seminar for Medical Social Workers Consent Form

You are invited to be in a research study of grief education for social workers with emphasis in theories of grief, personal death awareness and importance of ritual and grieving. You are invited as a possible participant because of your employment or internship in the HCMC Social Service Department. I ask that you read this form and ask any questions your may have before agreeing to be in this study.

The study is being conducted by: Colleen Hoffman, MSW student
Augsburg College

Background Information:

The purpose of this study is to gather information from medical social workers to evaluate their perceptions to a grief education seminar: The Grief Journey: Our Patients, Ourselves. The information will provide data for my thesis.

Procedures:

If you agree to be in this study, we ask you to do the following: complete a pretest and posttest questionnaire, participate in the seminar, and complete a program evaluation.

Risks and Benefits of Being In the Study:

The study has the following risk: discussion of your experiences of both personal life experience with death and your professional experience with grief, dying and death with patients/families may evoke sad memories or emotions. The participants are provided with the Employee Assistance Program resource (EAP) for confidential professional counseling at no charge.

Benefit to participant: Six Social Work Minnesota Board of Continuing Education Units (CEUs) upon completion of the seminar.

Confidentiality

The records of this study will be kept private. In any sort of report I might publish, I will not include any information that will make it possible to identify any participant. Research records will be kept in a locked file. Only the researcher will have access to the records.

Voluntary Nature of the Study

The researcher conducting this study is Colleen Hoffman. You may ask any questions you have, now or later, by contacting me at my work telephone, (612) 347-2254 or at home, (612) 595-8605. You may also contact my thesis advisor: Rosemary Link at Augsburg College, phone (612) 330-1147.

*You will be given a copy of this form for your records.

Statement of Consent:

I have read the above information. I have asked questions and have received answers. I hereby consent to participate in the study.

Signature_____ Date_____

Signature of Investigator_____ Date_____

Appendix D

HCMC SOCIAL SERVICES STAFF DEVELOPMENT PRESENTS:

"THE GRIEF JOURNEY: OUR PATIENTS, OURSELVES"

This seminar will demonstrate the benefits of personal death awareness for the medical social work professional and its application to grief theories in our culture.

5 Social Work CEUs are offered

DATES: **Thursday, January 23, 1997 or Thursday, January 30, 1997**

Time: **8:30 a.m. to 4:00 p.m.**

Place: **A-9 Conference Room (Side B)**

Presenter: **Colleen Hoffman, LSW**
Augsburg College Masters of Social Work Student
HCMC Social Worker

Appendix E

Grief Seminar Registration Form

Please return registration form to Kathy Sieben by January 16, 1997

Name:_____

Position:_____
Agency

Mailing Address:_____

Daytime Telephone:_____

Social Security Number (for CEU records only):_____

I will be attending (please check one): _____ **Thursday, January 23, 1997 or**

_____ **Thursday, January 30, 1997**

Appendix F

Certificate of Attendance

THE GRIEF JOURNEY: OUR PATIENTS, OURSELVES

This is to certify that

_____

has completed 5.0 contact hours of continuing education designed to meet the requirements for the State of Minnesota Board of Social Work for their attendance on January 23, 1997 or January 30, 1997

_____

Colleen M. Hoffman, LSW
Program Sponsor & Presenter

Appendix G

Hennepin County Medical Center
HCMC
Level 1 Trauma Center

701 Park Avenue
Minneapolis, MN 55415-1829
612-347-2121

Dec. 11, 1996

Rita Weisbrod, Ph.D., Chair
Augsburg College Institutional Review Board
Augsburg College
2211 Riverside Avenue, Box 186
Minneapolis, MN 55454-1351

Re: Colleen Hoffman, M.S.W. Candidate

Dear Dr. Weisbrod,

I am writing you on behalf of Colleen Hoffman, M.S.W. graduate student at Augsburg College. Colleen has been an employee of Hennepin County Medical Center Social Service Department for the past two years and has earned the respect and support of her colleagues. She will be conducting a research study at HCMC titled "The Grief Journey: Our Patients, Ourselves." Colleen will conduct an in-service in January 1997 specifically designed for medical social workers on the topic of grief self-awareness and grief theory. This information will be very valuable for the staff and I give Colleen my enthusiastic support for choosing this critical topic.

Colleen has my permission to ask the medical social workers to participate in this study. The surveys will be group administered and participation is voluntary. I am comfortable that confidentiality will be protected by the anonymity of the survey design, and that Colleen has taken steps to respond appropriately to any staff whose participation in this study has a negative impact on them. In addition, she has my wholehearted support in conducting her research study: An exploration of Medical Social Workers Participation in a Grief Education Seminar. We look forward to the contribution that her work will make to the quality of social services at HCMC.

Please feel free to call me at 347-2250 with any questions or concerns you may have.

Sincerely,

Barbara M. Klatt

Barbara M. Klatt, LICSW
Director of Social Services

Appendix H
Exempt Review

Hennepin County Medical Center
Minneapolis Medical Research Foundation
Hennepin Faculty Associates

Human Subject Research Committee
Project Summary

PLEASE NOTE: THIS FORM MUST BE TYPED

For IRB submission, please enclose 1 copy of project summary, protocol and questionnaire as applicable.

Date: 1-2-97

Request for Exempt Review:

- _x_ research conducted in established or commonly accepted educational setting, involving normal educational practices
- _____ research involving the use of educational tests, survey procedures, interview procedures or observation of public behavior
- _____ research involving the collection or study of existing data, documents, records, pathological specimens, or diagnostic specimens
- _____ research and demonstration projects which are conducted by or subject to the approval of any Federal Department or Agency
- _____ taste and food quality evaluation and consumer acceptance studies

Principal Investigator:
Colleen Marie Hoffman, LSW

Department/phone/pager:
Social Services/347-2254/336-0571

Co-Investigators/Departments:

Signature of Chief of Service/Department Head
Barbara McRitt, Social Service Director

Project Title:
An Exploration of Medical Social Workers' Participation in a Grief Education Seminar

Brief Description of the Study:
The purpose of this research is to implement and evaluate a grief and death education seminar for medical social workers at HCMC. The purpose is to educate social workers in the multiple facets of grief with emphasis on personal death awareness and how social workers can best assist individuals who are grieving.

Expected Start Date: January 23, 1997 Expected End Date: January 30, 1997

Number of Subjects: 37

Will any of the following subjects requiring special IRB protection be part of the proposed research?

___children ___prisoners ___pregnant women ___fetuses
___embryos in human in vitro fertilization
___handicapped or mentally disabled
_X_none of the above

Will any of the proposed research be conducted away from the HCMC campus? No Yes

Sponsors/Funding Source:
HCMC Social Services Department

Is there a conflict of interest with any of the investigators? No Yes
If yes, please explain.

How will patient confidentiality be maintained?
Anonymous questionaires are given to subjects. The records of this study will be kept private. In any report published, identifying information will not be included. Records are kept in a locked drawer; only the researcher will have access to the records. To be Completed by the IRB----

Principal Investigator:
Colleen Marie Hoffman, LSW

Project Title: **An Exploration of Medical Social Workers' Participation in a Grief Education Seminar**

_X_ Approved (Exempt Status: **45 CFR 46.101 #1**)
_____ Not Approved

01/08/97

Signature Date

Upon receipt of an approval, you may begin your research. If you have any questions, please call 347-8528.

Appendix I

AUGSBURG

C•O•L•L•E•G•E

January 21, 1997

TO: Colleen M. Hoffman
255 Shelard Parkway #219
St. Louis Park MN 55426

FROM: Rita R. Weisbrod, Ph.D.
Chair
Institutional Review Board
612-330-1227 or FAX 612-330-1649
E-mail: weisbrod@augsburg.edu

RE: Your IRB application: "An Exploration of Medical Social Workers' Participation in Grief Education Seminar"

I have received the changes to your proposal and the approval letter from the HCMC IRB and am happy to report that it is now has IRB approval.

Your IRB approval number is **96-29-2**. This approval number should appear on the consent form for your seminar participants.

If there are substantive changes to your project which change your procedures regarding the use of human subjects, you should report them to me by phone (612-330-1227) or in writing so that they may be reviewed for possible increased risk.

Good luck to you in your research project!

Copy: Rosemary Link, Thesis Adviser

Appendix J

PROGRAM DESCRIPTION OF SEMINAR DESIGN:

THE GRIEF JOURNEY: OUR PATIENTS, OURSELVES

Colleen Marie Hoffman MSW, Presenter

HCMC, Minneapolis, Minnesota, 5/97

This section describes a one-day seminar on the subjects of grief and personal loss and death awareness designed to enhance preparedness of social workers in a medical setting to work with patients and families who are confronted with death and dying issues and to help participants explore their own perspectives on death.

This seminar was voluntarily attended by medical social workers employed at Hennepin County Medical Center, Minneapolis, Minnesota. The overall framework involved sensitivity training and used an experiential learning approach. The group presenter participated in the experiential learning exercises. In the development of this program the researcher reviewed several descriptions of similar workshops and courses in the literature.

Participants received copies of the agenda and seminar upon signing letters of consent to use their data for research. Upon completion of the seminar participants were provided with social work continuing education units. See appendix K, Seminar Training Materials for contents of participants learning packets.

Benefits

Personal death awareness is important and relevant to clinical or medical social work practice. This seminar was particularly designed for social workers to help them work effectively with patients and families, however it can be adapted for use in college classrooms, with other healthcare workers such as physicians, nurses, and other members of multidisciplinary teams.

A variety of techniques are used to present seminar materials such as lectures, large and small group discussion, handouts, references, resources, videos, music and poetry. The seminar agenda, questionnaire, evaluation and training materials are presented. See appendices for agenda and handouts.

The seminar is designed for a small audience. It was offered twice to limit size and opportunity for cross-coverage among social work teams. It is suggested that the group size be limited to 20 participants to allow for quality presentations and group discussion. The presenter acknowledges the expertise of a professional audience of peers; therefore seminar participants were encouraged to become actively involved in the process by sharing their clinical experience and insights in small and large group settings.

Preparation Needed for Seminar: "The Grief Journey: Our Patients: Ourselves"

Learning Objectives (Overall)

1. To provide an overview of grief
2. To explore personal losses and get in touch with grief
3. To share experiences and shared learning

Methods:

Presentation	Brainstorm session
Lecture	Participant presentations
Group discussion	

Materials:

Handouts

Videos, VCR, audiocassette player

Comfortable tables and chairs

Comfortable room

Sign for door that reads: "Quite Please, group in session"

Blackboard or flip chart

Paper, pens, pencils

Resource display table Coffee/refreshments/lunches

SIX WEEKS PRIOR TO PRESENTING SEMINAR APPLY FOR CEU'S FROM THE BOARD OF SOCIAL WORK. MAIL OUT ANNOUNCEMENTS AND REGISTRATION FORMS!

AGENDA OUTLINE FOR GRIEF EDUCATION SEMINAR

"The Grief Journey: Our patients, ourselves"

Minneapolis, Minnesota

Morning Session

I Introduction/Welcome

Introduction of presenter(s)

Introduction of participants (name tags optional)

note: remind participants to put their pagers on vibrate if they must carry them.

Discuss housekeeping items, restroom locations and telephones, invite participants to use as necessary.

II Review Agenda and outline

note: remind participants that you will make efforts to build in time for processing and self reflection.

III Video: "Its in everyone of us"

"This video is a reminder of our common humanity, our global family. It lets us feel the wisdom and truth that we all carry with us. It shows both adults and children. It will fill you with love, respect and compassion." Excerpt from video cover from Krutein & Pomeranz, 1987)

The objective for showing this video is to set the tone of the day for one of open discussion and mutual respect and trust.

IV Group Agreements (Context)

Objective/Instructions: The participants are reminded that they too are experts on grief. They are asked to design their own group agreements also referred to at times as "Group Rules"

Note: remind participants that they may find today that there is no 'right way' to work with the dying or bereaved. In the end death is still a very personal and individual event. It will be different for each person. "My hope today is to draw upon ourselves as we try to find the best approach for a particular patient or family" cmh

IV Grief theories and grief resources (lecture)

Materials: handouts needed: Grief theories, Normal Grief Responses, Symptoms and behaviors of unresolved grief, Anticipatory grief, Disenfranchised Grief, Complicated Grief.

Objective/Instructions: to lecture and ask participants to assist in naming grief theory (many may be familiar with E.Kubler-Ross) and ask for group discussion.

Refer participants to resources and explain when grief groups may be appropriate and when individual or family counseling is appropriate. Note the cultural and ethnic resources if available and appropriate to your population.

VI Nadeau-Johnson Loss Inventory and Personal Loss History

Materials: Nadeau-Johnson handout (appendix)

Objective: To increase awareness of the various kinds of losses throughout our lives.

Instructions: To help participants identify personal losses, read through the following lists and check those losses which you have ever experienced. Large group discussion. Presenter may want to volunteer to name the first loss from her inventory to prompt the group and demonstrate emotional risk-taking.

Personal Loss History

Materials: Personal Loss History is provided on the backside of the Nadeau-Johnson Loss Inventory.

Objective: Awareness of the various losses throughout our lives and feelings and effects associated with the losses.

Instructions: in the spaces provided, (these losses may be from any category from the Nadeau-Johnson Personal Loss Inventory) Write a brief description or words to describe your loss, your age at the time of the loss, your feelings about the loss, the response of others, your ways of coping, and the effect on your life or any unfinished business.

Break for Coffee/refreshments (15 minutes)

VII Video: "To touch a Grieving Heart: Healing ways to help ourselves and others walk the journey of grief"

This video is presented by Kathleen Braza,MA Grief Counselor and Certified Thanatologist. This video offers practical insights and helps viewers to overview the grief process. Some of the topics discussed are: Talking, sharing and reminiscing, offering permission to grieve, What can I say? Taking care of unfinished business, healing rituals, memory work, finalizing a loss and Be there and listen.

Objective/Instruction:

Discussion of video key points is helpful for an overview of the grief process and to share professional intervention strategies

VIII Personal Grief/Death Awareness

Small group discussion exercises/Role plays

Materials: handouts (see appendices)

Objective: To reflect and discuss participants' earliest death experiences.

Instructions*: ask participants: As a caregiver, how have you experienced and recovered from grief? Explore your greatest strengths you offer others, explore weakness. Explore your greatest feelings and beliefs of life and death.* Record of your thoughts and feelings concerning the question on paper provided.

Small Group Exercises (see handouts : Personal death awareness/Interventions, see appendices)

Ask Participants the following questions and to discuss their answers with their small group.

1. What are the three most difficult aspects of your work with the dying or bereaved?

2. How do you debrief after the death of a patient?

3. Lifeline exercise: ask participants to draw their lifeline, predict how long they will live, and how it feels to make an estimate of one's life span.

4. What will be your legacy? The participants are given an opportunity to leave a legacy by describing the characteristics by which they would like to be remembered.

Role Plays/Vignettes (Grief Sketches in appendix)

Objective: To connect theory with practical applications/discuss possible interventions

Instructions: Break into small groups of dyads or triads. Read the grief sketch assigned to the group by presenter and role play (act out) the responses or interventions. (As with any exercise, the option to not participate in a role play and to instead observe is offered)

Lunch Break (30 minutes)

Note: soft music may be played, poetry shared before breaking for lunch and prior to getting started again after lunch.

Afternoon Session

IX Children's Grief (lecture and discussion)

Materials: handouts (appendices)

Objective: To discuss the variables associated with grief and children developmentally.

X Getting in touch with our Grief (large group and discussion)

Materials: handouts (appendices)

Objective: participants get in touch with their grief/loss experiences

Instructions: Participants record their losses according to instructions by the presenter. (See appendix for detailed instructions)

Caveat: This exercise may evoke feelings of sadness and/or anticipatory grief responses as participants imagine the losses as real and tangible. Allowing time for reflection, discussion and processing is very important.

Break (15 minutes)

XI Video: "A Family in grief: The Ameche Story"

Objective/Instructions: This is story of a family's grief responses after the sudden/unexpected death of their son and brother. Group discussion will follow.

XII Perspectives on Death: Letter Writing Experience

Materials: handout (see appendix)

Objective/Instructions: Write a letter to someone deceased, a letter in which "unfinished business" and an attempt to deal with unresolved feelings are addressed. The letter should be signed. Share the contents of the letter with other participants. (Sharing the letter is optional)

Note: The presenter of the seminar presented at HCMC read her own letter to her brother in law who had died to demonstrate a willingness to take an emotional risk. The song: "The Circle of Life" by Elton John was played to set the stage for quiet reflection. Allow participants the option to move around the room or to a private area nearby if possible.

XII Sharing our stories - "This is why I do this Moments"

Large group Session

Materials: 3x5" cards

Objective/Instructions: To bring closure to the day's session and to provide opportunity to discuss reflections from the day and successful interventions medical social workers use in their practice. Share a favorite story from your practice that has touched them personally or professionally. Each participant is asked to share his or her experience with the group prior to adjournment

Presenter's Example: Encouraging family, friends or caregivers to bring in photos and momentos that tell us the identity of the patient behind the tubing, masks, IV poles and other medical equipment that serves to detach and dehumanize the patient. Be creative: Ask participants to explore ideas and suggestions with each other to validate their knowledge.

Adjournment

Distribute Program evaluations and Certificates of Attendance /CEU's

Note: All or some of the exercises can be used if time allows...you may choose to omit some depending on the group cohesion and time allotted in the schedule. Participants who attend voluntarily should be given the opportunity to pass even though it may not be clearly spelled out in the group agreements.

APPENDIX K

SEMINAR TRAINING MATERIALS

"THE GRIEF JOURNEY, OUR PATIENTS, OURSELVES"

Seminar Agenda

The Grief Journey: Our Patients, Ourselves

HCMC - Colleen Hoffman, LSW Presenter

8:30-9:00	Registration, Consents, Questionaires and Packets Distributed
9:00-9:15	Welcome and Video: "It's in Every One of Us"
9:15-9:30	Grief Theories and Resources (lecture)
9:30-10:15	Loss Inventory and Personal Loss History
10:15-10:30	Break/Refreshments
10:30-11:30	Video: "To Touch a Grieving Heart: Healing Ways to Help Ourselves and Others Walk the Journey of Grief"/discussion
11:30-12:00	Personal Grief/ Death Awareness Small Group Discussion Exercise/Role Plays Vignettes
LUNCH	
12:30-1:00	Children and Grief (Rosemary Froehle, MSW)
1:00-2:00	Personal Grief Death Awareness Exercise "Getting in Touch With Our Grief" Small Group Discussions
2:00-2:45	Video: "A Family in Grief: The Ameche Family"/Discussion
2:45-3:00	Break
3:00-3:30	Letter Writing Exercise
3:30-4:00	Sharing Our Stories: "This is Why I Do This Moments"
4:00	Adjournment

Please compete program evaluation before departing!

Thank you

Grief Theories

I. **Stages of Grief by Elizabeth Kubler-Ross (1969)**

1. Denial and Isolation
2. Anger
3. Bargaining
4. Depression
5. Acceptance

II. **J. W. Worden (1982)** believes that mourning involves four tasks:

1. To accept the reality of the loss
2. To experience the pain of grief
3. To adjust to an environment in which the deceased is missing
4. To withdraw emotional energy and reinvest it in another relationship

III. **Therese Rando (1993)** Six "R" Processes of mourning necessary for healthy accommodation of any loss.

1. Recognition of the loss
2. React to the separation
3. Recollect and reexperience the deceased and the relationship
4. Relinquish old attachments to the deceased.
5. Readjust to move adaptively into the new world without forgetting the old
6. Reinvest

Compiled by Colleen Hoffman, 1997, presented at "The Grief Journey: Our patients, Ourselves" Seminar, HCMC

NORMAL GRIEF RESPONSES

Many people worry if they are grieving the "right" way and wonder if the feelings they have are normal. The following are natural and normal grief responses. Validation of these feelings by the medical social worker is important to the resolution of their grief.

MOST PEOPLE WHO SUFFER A LOSS WILL EXPERIENCE ONE OR MORE OF THE FOLLOWING:

* feel tightness in the throat of heaviness in the chest.
* Have an empty feeling in their stomach and lose their appetite.
* Experience an increase in appetite to feed and comfort themselves in their pain.
* Feel restless
* Find it difficult to concentrate
* Feel as though the loss isn't real, that it didn't really happen.
* Sense the loved ones presence. Finding themselves expecting the person to walk in the door at the usual time, hear the loved one's voice, seeing their face.
* Wander aimlessly. Forgetfulness. Unable to complete projects they've started.
* Have difficulty sleeping. Frequent dreams of the deceased.
* Sexual difficulties.
* Assume mannerisms or traits of their loved one.
* Feelings of guilt, anger or frustration over things that happened or didn't happen in their relationship with the deceased.
* Feel intense anger at the deceased for leaving them.
* Feel they need to take care of other people who feel uncomfortable around them.
* Feel the need to tell and retell and remember things about the loved one and the experience of their death.
* Feel their mood changes over the slightest things.
* Cry at unexpected times and unexpected places.

Compiled by Colleen M. Hoffman, presenter at "The Grief Journey: Our Patients, Ourselves," HCMC, 1/97

ANTICIPATORY GRIEF

Fulton & Fulton (1971), list the following characteristics of anticipatory grief

- Depression
- Heightened concern for the terminally ill person
- rehearsal of the death
- attempts to adjust to the consequences of the death

Anticipatory grief allows for:

- absorbing the reality of the loss over time
- finishing unfinished business with the dying person
- beginning to change assumptions about life and identity
- making plans for the future

DISENFRANCHISED GRIEF

When someone experiences a loss that cannot be acknowledged openly and does not receive social or emotional support from others; i.e.: homosexual partners, relationships kept secret: partners involved in infidelity, etc.

COMPLICATED GRIEF

Traumatic deaths related to extraordinary circumstances are often associated with complicated grief; i.e.: homicide, suicide, sudden death, catastrophes, etc.

Compiled by Colleen Hoffman, LSW for "The Grief Journey: Our Patients, Ourselves," Seminar at HCMC, 1/97

SYMPTOMS AND BEHAVIORS OF UNRESOLVED GRIEF COMPILED BY T. RANDO (1982)

The following are lists adopted by Lindemann (1944), Lazarre (1979), & Worden (1982)

Lindemann:

* Overactivity without a sense of loss
* Acquisition of symptoms belonging to

the last illness of the deceased

* Development of a psychosomatic medical illness
* Alteration in relationships with friends and relatives
* Furious hostility against specific persons somehow connected with the death (e.g., doctor, nurse)
* Formal conduct that masks hostile feelings and resembles a schizophrenic reaction in Shiite there is a lack of emotion
* Lasting loss of patterns of social interaction
* Acts detrimental to one's own social and economic existence (e.g., giving away belongings, making foolish economic deals)
* Agitated depression with tension, agitation, insomnia, feelings of worthlessness, bitter self-accusation, and obvious need for punishment, even suicidal tendencies.

Lazare: The following diagnostic criteria for unresolved grief occur when one or more of these symptoms/behaviors transpires after a death and continues beyond 6 months to one year. The greater the number of symptoms or behaviors, the greater the likelihood of unresolved grief.

* A depressive syndrome of varying degrees of severity since the time of death often accompanied by persistent guilt and lowered self-esteem
* A history of delayed or prolonged grief, indicating that the person characteristically avoids or has difficulty with grief work
* Symptoms of guilt and self-reproach, panic attacks, and somatic expressions of fear such as choking sensations and shortness of breath
* Somatic symptoms representing identification with the deceased, often the symptoms of terminal illness
* Physical distress under the upper half of the sternum, accompanied by expressions such as "There is something stuck inside"
* Searching that continues over time, with a great deal of random behavior, restlessness, and moving around
* Recurrence of symptoms of depression and searching behaviors on specific dates, such as anniversaries of the death, birthdays of the deceased, achieving the age of the deceased and holidays, that are more extreme than would be expected
* A feeling that the death occurred yesterday, even though the loss took place months or years ago

* Unwillingness to move the material possessions of the deceased after a reasonable amount of time has passed
* Changes in relationships following the death
* Diminished participation in religious and ritual activities that are part of the mourner's culture, including avoidance of visiting the grave or taking part in funeral rituals
* An inability to discuss the deceased without crying or having the voice crack, particularly when the death occurred over a year ago
* Themes of loss

Worden:

* A relatively minor event triggering major grief reactions
* False euphoria subsequent to the death
* Overidentification with the deceased leading to a compulsion to imitate the dead person, particularly if the mourner lacks the competence for the same behavior
* Self-destructive impulses
* Radical changes in lifestyle
* Exclusion of friends, family members, or activities associated with the deceased
* Phobias about illness or death

These lists are not all-inclusive. Varying symptoms will occur.

"Without an understanding of and appreciation for these variables and how they affect a particular individual's grief experience, *no* judgments can be made about the person's grief response" (Rando, 1982, p.64).

C.M. Hoffman, "The Grief Journey: Our Patients, Ourselves," seminar presented at HCMC, 1/97

NADEAU-JOHNSON PERSONAL LOSS INVENTORY

We all experience various kinds of losses throughout our lives. To help you identify your personal losses, read through the following list and check those losses which you have experienced.

I. LOSS OF POSSESSIONS

_____ belongings destroyed by fire
_____ automobile accident
_____ lost car keys
_____ belongings being stolen
_____ damage by natural disaster
_____ home sold
_____ foreclosure on possessions
_____ pets
_____ bankruptcy
_____ money through bad investment
_____ business collapse
_____ stock market crash
List Others:

II. DEVELOPMENTAL LOSSES

_____ giving up favorite toy/blanket
_____ outgrowing belief in Santa Claus, Easter Bunny, Tooth Fairy
_____ status as an only child
_____ parental attention, i.e. financial support
_____ high school/college graduation
_____ moving out of parents' home
_____ loss of youth
_____ puppy love
_____ freedom of single adult
_____ freedom as children are born
_____ you become the "older generation" in your family
_____ retirement
_____ grown children leave home
List Others:

III. LOSS OF PARTS OF ONE'S SELF

_____ body parts, i.e. hair, teeth
_____ body functions, i.e. vision, hearing, walking
_____ fertility
_____ name when female marries
_____ health
Self definition roles:
_____ parental role
_____ spouse role
_____ child role
_____ employee role
_____ provider role
_____ caretaker role
Dreams and expectations:
_____ career expectations
_____ aspirations for a child
_____ financial security
List Others:

IV. LOSS OF SIGNIFICANT OTHERS

_____ childhood friend moves away
_____ first serious relationship with another person
_____ college roommate at graduation
Heroes/Heroines:
_____ sports hero
_____ movie hero
_____ national hero
_____ professional role model
_____ divorce from spouse
_____ debilitating illness of loved or
_____ family separation
Deaths of:
_____ spouse
_____ parent
_____ grandparent
_____ stillbirth/miscarriage
_____ child
_____ sibling
_____ aunt/uncle
List Others:

A PERSONAL LOSS HISTORY

Your Loss	Your Age	Your Feelings	The Response Of Others	Your Ways Of Coping	The Effect on Your Life or Any Unfinished Business

PERSONAL DEATH AWARENESS

I. LIFE LINE

A. In the space below draw a line that you think best represents your total life span. The line can be any shape of length you think is most appropriate.

B. Consider this line to be your total life span. Place a slash mark at any point along the line where you think you are today in your life's chronology.

C. Complete the following sentences by filling in the blanks:

I expect to live until age_____
I am presently age_____

D. How did it feel to commit yourself to a definite life span?

E. I was uncomfortable in estimating my remaining life span because:

F. I was comfortable in estimating my remaining life span because:

Adapted from Van Beck (1993) & L. Walton (1994)
"The Grief Journey, Our Patients, Ourselves," Seminar at HCMC, 1/97
C.M. Hoffman

PERSONAL DEATH AWARENESS
WHAT WILL BE YOUR LEGACY?

A. If I have a choice, I would prefer to die in _____.
(location)

because:_____

_____

B. What I want people to most remember about me:

1. My interest in:

2. My traits of:

3. My accomplishments:

Adapted from L. Walton (1994)
"The Grief Journey: Our Patients, Ourselves," presented at HCMC, 1/97 C.M. Hoffman

Small Group Exercise

What are the three most difficult aspects of you work with the dying or bereaved?

1.

2.

3.

How do you debrief after the death of a patient with whom you have had either long term or emotional involvement? Does this afford you sufficient release or closure? If not, what can you do to achieve more of this?

(Adapted from Rando, 1982) Compiled by Colleen Hoffman, 1997 "The Grief Journey: Our Patients, Ourselves" Seminar HCMC

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Grief Sketch

Woman: You are a 51 year-old single woman whose mother just died. The two of you always lived together and had a close but ambivalent relationship. You cared for your mother during her lengthy illness, which involved several hospitalizations. Your mother was not an easy person to get along with and several times during her final years you told her in anger that if she didn't shape up, you would send her off to a nursing home. This last hospitalization has been very long and while you realize you wouldn't really have sent her to a nursing home you had also come to miss your mother. You're at the bedside as she died and become overwhelemed with feelings of grief about having said these things.

Social Worker: You have just been paged by the nurse in MICU #2 as a woman is sitting by the bed of her mother who has just died and by nurse report "Crying loudly, has been inconsolable, refusing to leave the bedside and repeatedly saying: 'I'm so sorry, I'm so sorry'". Your task is to help her reality test her guilt and to find a way to cope with it at this time and be able to at some time leave the bedside.

Woman: Your 8 year old son has sustained a severe Traumatic Brain Injury 5 days ago. The physicians tell you he is dying--they are in the process of completing the tests to comply with brain death criteria. You are having difficulty understanding how your son can look so good and still be almost dead. He does have a few bruises and scratches on his face, a broken leg, and head wrapped in bandages--but for the most part his color seems good and he is breathing with the aid of the ventilator--he seems to be asleep. You know he's not but you so desparately want to believe that he will wake up again, you're exhausted, numb and now you overhead the nurse at the station whisper to someone else that they're concerned because you're not crying and grieving when you are at the bedside. Here comes that social worker you have been meeting with every day since Tommy was injured.

Social Worker: You have been asked by the Intensivist to talk with the mom because the nursing staff has reported that they have not noted any grieving behaviors for the last couple of days. Everyone is worried about mom as she seems to be withdrawing more and more from staff. Your task is to assess whether you believe her reaction is within norms or whether she should be seen by a psychiatrist, which is what some of the team is recommending as mom walked out of a meeting with the neurosurgeon as he was talking to the family about the tests being done to establish brain death. What would you say to the mother and how would you go about making this assessment? What of your beliefs/comfortableness with death and grieving may be involved?

Man: You are a 72 year old man dying from Congestive Heart Failure. Your spouse, 2 sons, 1 daughter and 1 brother all visit about every other day but everyone keeps their visits very brief--about 5-10 minutes at the most. You want them to spend more time with you. You ask to see the floor social worker as during a previous hospitalization he was very respectful, helpful and kind to you while helping with some problems with your insurance.

Social Worker: You are on the station when you are informed by the nurse that the patient in room 3124 wamts to see you. He asks for your help in intervening with his family so they will spend more time with him. What is your response? What type of intervention, if any, would you plan?

CHILDREN/GRIEF

"IF A CHILD IS OLD ENOUGH TO LOVE, THEY ARE OLD ENOUGH TO MOURN"

I. Stages of Readiness/Understanding of Finality of Death

A. Toddler - No understanding of death finality
Can sense tension/react to emotion
Concern is separation/abandonment

B. Preschool-Concrete not abstract thinking
Separation is temporary
Dead things come back alive
Death is accidental not inevitable
May think their wishes could cause death
Starts to ask questions about death/reflective of own/others exp

C. School Age - Beginning to see finality
May continue with Magical Thinking
Personifies death-"Boogie Man"
May focus on "gory" details
May associate death with wrong doing

D. Teen Age - Denial of own death
Daring death
Knows its final but not for themselves
Concern about how death affects body

II. Children may:

A. Resort to routine to help bear grief
Return to TV, Play (this is child's work)
Return to activites shared with dead person

B. Mask feelings in presence of adults--distancing is way to protect/preserve themselves

C. Regress to earlier behavior(Thumb sucking, temper tantrums, bed wetting,temporary school problems)

D. Feel guilt/responsibility for death of loved one

E. Be concerned about who is going to take care of them

F. Fear death of parents/caretakers

G. Response may appear more intense

H. Experience increased depression, risk taking behaviors, (increase use of Etoh/drugs, sexual activity), decreased academic performacne, decreased socialization, appear hypermature

CHILDREN/GRIEF

III. Children need:

A. Direct, simple explanations in age appropriate context, language, repeated
B. Routine/consistent caregivers as much as possible
C. Loving reassurances they didn't cause death
D. Acknowledgement from adults ok to talk about death
E. Ok and modeling from adults re expressions of grief
F. Acknowledgement from adults that they, too, may have difficulty with questions raised by death
G. To be involved in family decision making (age app)
H. Encouragement/choices in participation of rituals
I. Death part of life cycle/support to grieve- and to grive periodically as needed
J. Recognition of push/pull(they cannot sustain emotional pain for long periods)
K. Adult willingness to struggle with them to understand death
L. Recognition that children have varying degrees of social skills in handling "awkward, unusual situations
M. To have death preparation part of all of life

Compiled by Rosemary Froehle (1/97)
for The Grief Journey: Our Patients, Ourselves
Presented by Hoffman, HCMC 1/97

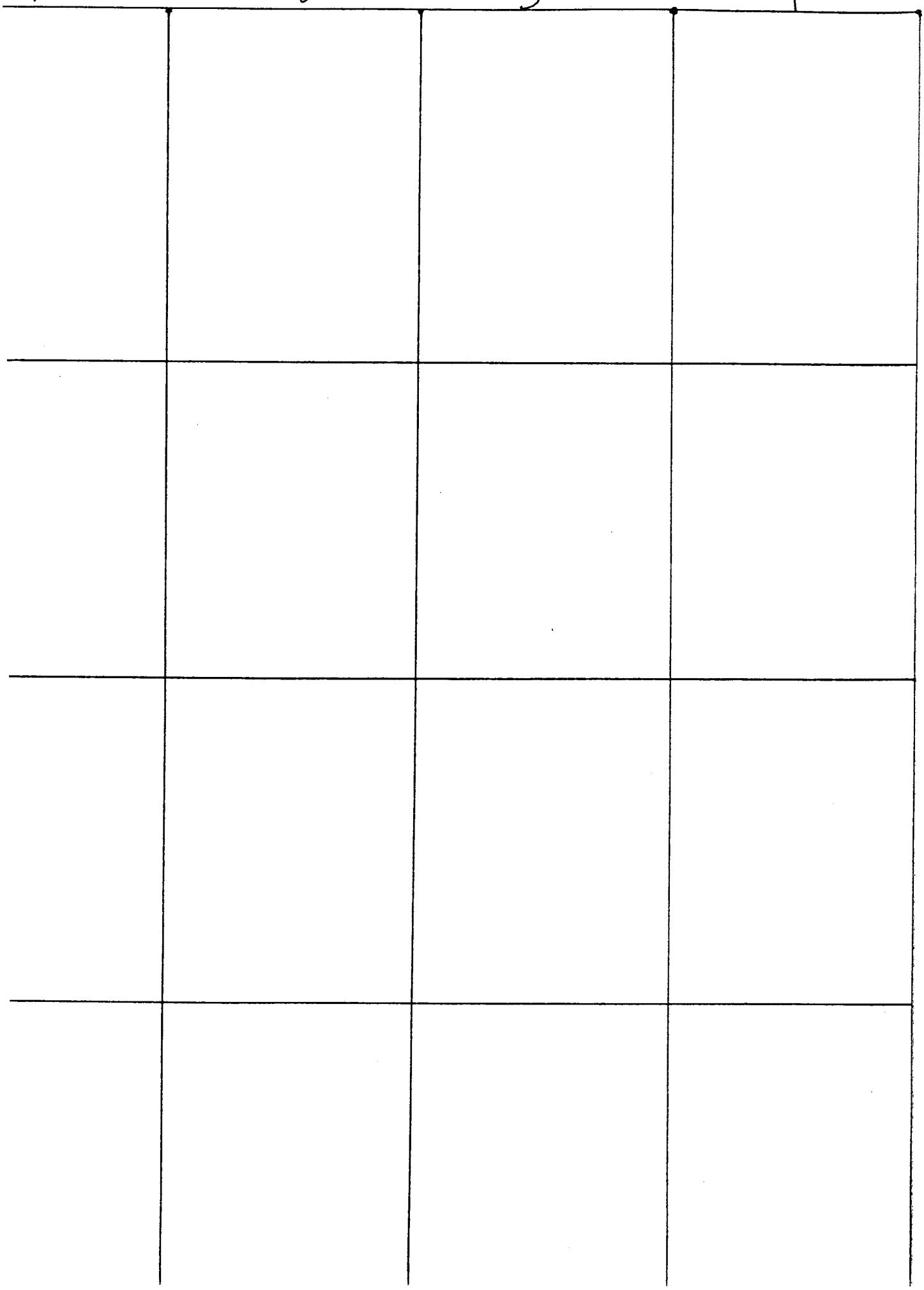
Group Exercise: To Help Staff Get In Touch With Grief

ıstructions:

1. Divide your paper in half, short way and long way.
2. Divide each of these sections in half also, to end up with 16 squares.
3. In 8 of the squares, write in the name of the most meaningful people in your life.
4. In the other 8 squares, list "things" that are important to you - job, pet, music, gardening, health, eyesight, etc.
5. Now put an X thru the 2nd square in line 1; square 1 and 4 in line 2; and square 1 in line 4 (total of 4).
6. Exchange your paper with person next to you.
7. Each of you cross (X) out 4 more squares (any).
8. Give paper back to originator.
9. See the squares X out. These are your losses. Get in touch with how you would feel if these losses were real.

ırpose: Get in touch with grief.

from B. Britz St. Gabriel's Hospital Grief Support Program, Little Falls, MN
fman, Master's Thesis


1
2
3
4

PERSPECTIVES ON DEATH
LETTER WRITING EXERCISE

Write a letter to someone deceased, a letter in which "unfinished business" and an attempt to deal with unresolved feelings are addressed. The letter should be signed. Share the contents of the letter with other members of the seminar. (sharing is optional)

Adapted from Moore(1984) C.M. Hoffman, "The Grief Journey: Our Patients, Ourselves," Seminar presented at HCMC, 1/97